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Sexual Desire Disorder in Lesbian-Feminist Couple: The Intersection of Therapy and Politics

Introduction

It is obvious to therapists experienced in working with both heterosexual and homosexual couples that in most cases sexual orientation is irrelevant to the course of treatment. There are striking exceptions to this rule, however, especially in the treatment of sexual problems. It is therefore appropriate that this chapter be devoted to a case that typifies the "signature" sexual problem of gay women, an affliction so common that lesbian comics crack jokes about it and it has been colloquially named "lesbian bed death." Mickie and Cheryl came to sex therapy for help with low sexual desire and low sexual frequency—three to four sexual episodes per year—in a long-term monogamous relationship.

Certainly lesbian couples have not cornered the market on low sexual desire; it may be the most common sexual problem for all couples. But two things make this disorder stand out in the lesbian community. First, data suggest that sexual frequency may be lower normatively for lesbian couples than for any other type of gender pairing (Blumstein & Schwartz, 1983). Moreover, this may not be a recent phenomenon. The lesbian historian Lillian Faderman has written extensively about the existence of lesbian relationships devoid of genital sexuality in the 19th century (1981) and lesbian relationships where sexuality was greatly deemphasized in the 20th century (1991). And Faderman (1991, p. 304) quotes the French author Colette (1930), "who wrote about lesbianism from her firsthand experiences":

In living amorously together, two women may eventually discover that their mutual attraction is not basically sensual . . . What woman would not blush to seek out her amie only for sensual pleasure? In no way is it passion that fosters the devotion of two women, but rather a feeling of kinship.

Second, sexual desire problems among lesbians are discussed widely within the lesbian community in political terms, a phenomenon unparalleled among heterosexuals or even gay males. This is part of a broader tendency of lesbians to politicize all sexuality and indeed most aspects of day-to-day living. The feminist movement of the 1970s coined the phrase, "the personal is political," and lesbians in the latter 20th century have taken this belief very much to heart. Indeed, Faderman's history of 20th-century lesbianism. Odd Girls and Twilight Lovers (1991), includes an entire chapter titled "Lesbian Sex Wars in the 1980's," and much of this chapter is devoted to ideological conflicts touching upon the issue of low sexual frequency among lesbians.

Because even experienced sex therapists may be unfamiliar with the political meanings of sex within the lesbian community, it is useful to preface this case presentation with a brief discussion of both clinical and cultural aspects of low desire in gay women. For a more thorough exposition of clinical and therapeutic perspectives, the reader is referred to my chapter in Sexual Desire Disorders (Nichols, 1988).

There seems little doubt that low sexual desire is more common among lesbian couples than among other couples, and that most low desire is secondary, rather than primary, in nature. That is, lesbians, whose predominant form of sexual behavior is serial monogamy, seem to begin relationships with about as frequent sexual activity with their partner as do heterosexuals or gay men. But within I to 2 years, sexual activity drops dramatically: In the Blumstein and Schwartz study (1983) only about one third of lesbians in relationships of 2 years or more had sex once a week or more and 47% had sex once a month or less. By contrast, among

heterosexual married couples two thirds had sex once a week or more and only 15% had sex once a month or less. Most lesbians report a strong sexual desire in the beginning of their relationships—in other words, their dysfunction is not primary—although many report that the rapid and extreme decrease in activity is a pattern in all their long-term relationships.

Therapists within the lesbian and bisexual community have discussed this issue widely and proposed various theories for the relative diminution of lesbian relationships (Burch, 1987; Loulan, 1985; Nichols, 1987). Some causes seem fairly obvious. Because women are culturally socialized to be less sexually assertive than men, lesbian couplings suffer from the lack of a "trained initiator"; one might hypothesize that frequency in heterosexual couples is often determined by the male partner. Because women are similarly socialized to be less attuned to their own sexual needs and even the physiological indicators of arousal, they simply may not experience desire in the same visceral way. Indeed, one lesbian sex authority has suggested that women should not expect to feel desire as a physical phenomenon; Loulan (1985) encourages lesbians to focus on their willingness to have sex rather than on their desire to have sex. Moreover, many women appear to have intimacy needs fulfilled by physical, nongenital affection rather than genital contact. Indeed, the stereotypical low-frequency lesbian couple exhibits an abundance of cuddling, touching, and other expressions of nonsexual closeness.

Women in this culture also seem to be more conflicted and guilt ridden about exhibiting strong sexual drives, and, again, pairings of two women double this possible source of sexual inhibition. Because women are sexually assaulted far more frequently than are men in contemporary society, lesbian relationships also double the probability that at least one partner will have a traumatic history of incest, molestation, coercion, or other sexual abuse. So, simply based on gender and cultural experiences, female-female pairings are more likely to be "sexually disadvantaged." Within the lesbian community, this problem is often compounded. Lesbians themselves have sometimes labeled certain sexual desires "bad," especially desires for men or sexual desires that seem to resemble male sexual preferences (ranging from an interest in pornography to an interest in penetration). Thus, the lesbian "sexual unconscious" contains not only the injunctions against sex taught to all women and traumatic memories of sexual abuse suffered by many women, but additional injunctions against homosexual behavior inculcated at an early age and proscriptions learned upon entry into a "supportive" lesbian community. For some lesbians, the unconscious is a virtual minefield, which may ultimately be simply too dangerous to enter. Inhibitions against sex may be a parsimonious way of avoiding conflict-laden fantasies, images, and desires.

Finally, most therapists within the lesbian and bisexual community' have agreed that lesbian relationships are often characterized by what is variously called fusion or merging, an extreme degree of intimacy in which individual identity seems almost to be lost. It is possible that within the context of already excessive closeness, the act of sex- characterized by even greater union, may be too threatening. For all these reasons, then, lesbian relationships may inherently be "loaded" for low sexual frequency.

Some lesbians have argued that the definition of sex—that is, what we literally "count" in studies of frequency—is skewed to a heterosexist standard (Clunis & Green, 1988). For example, neither researchers nor subjects themselves are likely to consider nongenital touching that does not lead to orgasm to be "sex." Yet this type of contact, very common in lesbian couples, may fulfill the sexual needs of the

women involved as well as does intercourse in a heterosexual couple. Huribert and Apt (1993) found lesbian women in couple relationships to be just as satisfied with their sex lives as were heterosexual women in relationships despite the fact that the lesbians had less frequent sex. And it may be that nonorgasmic sex is satisfying to lesbians in part because when they have sex that is directed toward orgasm, they seem to be more successful at it. While no comparable statistics exist, the clinician working with lesbians notices the infrequency of anorgasmia as a complaint among gay women. One can speculate that lesbian sexual techniques, primarily digital and oral stimulation, are more likely to reliably result in orgasm for women than is heterosexual intercourse. One might even wonder how the frequency of sex for heterosexual and homosexual women would compare if the only episodes sex researchers "counted" as sex for heterosexuals were ones that culminated in orgasm for the female partner.

Treatment of a lesbian couple complaining of low sexual desire is complicated by the subcultural context within which the couple is supported. This is particularly true of lesbian "baby boomers," those most likely to have been affected by the lesbian-feminist movement of the 1970s and the "sex wars" of the 1980s. Faderman (1991) begins her chapter on the latter with a quote from T. G. Atkinson: "I do not know any feminist worthy of that name who, if forced to choose between freedom and sex, would choose sex" (p. 246). Because feminists in these decades often saw sex as primarily a tool used in male hands to oppress women, they also saw freedom and sex as diametrical opposites. A decade ago, the lesbian community's polarization around sexual issues reached such heights that gay women could often be described as belonging to one of two camps, cultural feminists and the much smaller group of lesbian sex radicals. Cultural feminists tended to have fairly rigid views about which sexual behaviors, acts, and attitudes were or were not "politically correct." Their ideology was an extension of the 1960s and 1970s feminist critiques of sexual mores that served to oppress women, from the use of makeup and dress to transform women into sexual objects to the glorification of sexually violent/rape-like images. These critiques led some feminists to become suspicious of sex itself, at least of all sex between men and women. Andrea Dworkin (1980) probably epitomized the extreme with her statement that heterosexual sex in the missionary position —man on top—was inherently rape. Thus, cultural feminists within the lesbian community came to cast a critical eye on all sexuality that seemed to resemble heterosexual sex, labeling it "patriarchal" and "male identified." These women eschewed pornography, penetration, "butch-femme" roles, and rough sex. The sexual ideal proposed by these lesbians appeared to be that of total mutuality, sensuality rather than overt genitality, and complete "naturalness"—no toys, props, costumes, or roles. While this brand of sexuality may have represented the actual preferences of many gay women, it by no means included the preferences of all. Moreover, by codifying sex—labeling some acts "p.c." (politically correct) and other acts "p.i." (politically incorrect) — the cultural feminists, without meaning to, added to the already heavy burden of sexual acts proscribed for women.

Not surprisingly, some lesbians rebelled against these restrictions, and a few, the lesbian sex radicals, took their rebellion to breathtaking extremes. Borrowing heavily from the gay male sexual liberation of the 1970s, the sex radicals started S/M (sadomasochistic) clubs, butch-femme support groups, pornography magazines, and video companies and engaged in all manner of unusual sex acts from vaginal "fist fucking" to public sex orgies. Although the number of lesbian sex radicals was small, their ideas and practices became widely known and hotly debated within the community at large by the end of the 1980s. Variously denounced, banned, and

lauded, the sex radicals created vociferous and continuous dialogue about sex. Of utmost importance to the sex therapist treating lesbians born before 1975 is the fact that most of this generation of gay women has opinions, one way or the other, about the political implications of their sexuality.

Still another aspect of lesbian sexuality affects the baby-boom generation. Unlike gay men, many lesbians of this era view themselves as having chosen their sexual orientation for feminist/political reasons. As we shall see in the case discussion that follows, this factor can influence not only the etiology of sexual desire disorders but also the course of treatment.

A Case of Low Desire and Low Frequency

Initial Presentation

Mickie, a 44-year-old chemist, and her partner of 10 years, Cheryl, a 47-year-old social worker, called for sex therapy after referral by the therapist whom they had seen for couple counseling. This colleague, with whom I had worked closely in the past, thought that the couple could effectively work on sexual issues while they continued to work with her on their relationship, and I agreed to take on this somewhat unusual referral. From the beginning we all agreed that I would consult with this couple no more frequently than once every other week, to alternate with my colleague's sessions.

Our initial interview was cautious and tentative. Far from treating me with the deferential respect some clients display in facing a "professional," Cheryl and Mickie interrogated me and challenged my credentials — my credentials as a feminist and activist, that is. I was frank about being bisexual rather than lesbian; my frankness earned me some points that compensated for those I lost through bisexuality. My activist history and obvious familiarity with feminist theory, combined with the recommendation they had received from their couple therapist, whom they trusted, allayed their initial suspicions.

From the very first session my clients' political orientation toward the world determined therapeutic interventions. The women presented as prototypes of lesbian-feminists who had come of age during the 1970s women's movement: both cultivated an androgynous look, wearing no makeup, "practical" clothing (slacks, unisex shirts, boots), short un-styled hair, and little jewelry besides an occasional political button. Just as prototypically, they reported a couple history of relatively frequent, satisfying sex at the beginning of the relationship diminishing to sex three or four times per year during the last few years. Untypically, however, they also described a continuously high-conflict relationship. They had been in some variety of relationship counseling for most of their 10 years together and fought frequently and painfully. A few of their fights had degenerated into physical violence and most included mutual accusations of betrayal that included every incident of discord for the entire duration of their marriage.

Both women initially agreed that Mickie was the source of the sexual problems. Cheryl was characterized as "the passionate one" who had patiently and often not so patiently waited for Mickie, characterized with her WASP background as "the sexually repressed" member, to overcome her asexual heritage. After our initial sparring and rapport building and after eliciting some history of the relationship and sexuality within the relationship, I spent the remainder of the first session "training" the two

women in a particular view of sexuality, especially regarding low desire in lesbian couples.

I used the rhetoric of the feminist, lesbian, and gay movements to do this training. First, the view was presented that much female sexuality was not so much nonexistent as undiscovered, quoting Mary Jane Sherfey, an early feminist who believed that women were inherently more sexual than men but had been repressed in the service of patriarchy. The possibility was offered that Mickie might not necessarily be as asexual as both women believed. Next, the theories of C. A. Tripp (1975) regarding the need for a "barrier" to create sexual desire were discussed and related to women's tendency to rely on romance to create a barrier, thus experiencing waning sexual desire once the limerance phase of a relationship is over. Low sexual frequency among lesbians was considered in light of counterarguments that many lesbians are satisfied with nongenital relationships. This allowed Cheryl and Mickie to assert that they were not satisfied with only bugging and cuddling. It was suggested that sex might be separated from other conflicts in their relationship and that their sexual relationship might be potentially dependent on some factors—such as creating time for sex, structuring mood, and learning technique—that were mechanical rather than psychological or even political in nature. The women were presented with the view that sexual preferences might be a matter of style or personal taste rather than "right" or "wrong." Both women were given some reading material—copies of my articles and suggestions of lesbian sex books—and questionnaires to complete and return before the next session, which was scheduled for 2 weeks later.

The questionnaires, three extensive documents each covering symptom complaints, personal/family background, history of sexual orientation development, and descriptions of sexual behavior within the current relationship, were received before the second meeting. Several items were noteworthy in the women's responses. Mickie's self-report revealed an active childhood and adolescent sexuality, all with males, as well as frequent masturbation from an early age. Although she wrote that she felt guilty about sex, her guilt had not inhibited her behavior; she had had more than 20 male sexual partners with two marriages and, after "coming out" at age 33, six female sexual partners. Her ratings on a series of scales fashioned after the Kinsey continuum scales placed her in the bisexual range, and she viewed herself as a rather militant lesbian by choice: "I think in this society it is easier and more comfortable for me to be exclusively lesbian . . . I feel I clearly chose to be a lesbian. . . I think it's unnatural that heterosexual women chose to relate to the person they have sex with, since most of them would rather relate to women." Mickie's questionnaire on the current sexual relationship also conveyed some interesting responses: Several times she reiterated the feeling that sex in general, and particularly her sexual desires, were "dirty"; she admitted to sexual fantasies that included "torture"; she acknowledged desires for S/M sex, "dressing up" in roles during sex, dildo use, bondage, and the use of enemas—all of which the couple had actually enacted, at least occasionally. Mickie reported that she was "sometimes aroused, sometimes disgusted" by pornographic materials, and that she preferred "my turn/your turn" sexual encounters over attempts at simultaneous arousal. In general, Mickie reported a combination of guilt and shame over her own sexual desires, high performance anxiety surrounding her encounters with Cheryl, an expectation of criticism from Cheryl of her sexual functioning, and a sense that Cheryl's criticisms of her were appropriate. She acknowledged that she usually rejected Cheryl's advances toward her and that when the couple did have sex, it was because Mickie girded herself for the anxiety of a sexual encounter and initiated sex

herself. Not surprisingly, Mickie's predominant feelings about sex with Cheryl were of dread and anxiety.

Cheryl displayed the same stance in her questionnaires that she had in the first session—that Mickie was the source of the couple's sexual problems. She characterized herself as on the verge of leaving the relationship because of the lack of sexual activity and expressed great frustration about not being able to initiate sex with Mickie. Her own sexual history, while also "bisexual" (10 lifetime male partners, 18 female), was more clearly lesbian oriented. She recognized her lesbianism at age 16, when she fell in love with a girlfriend, and after several years of turmoil over her identity that included a suicide attempt at age 21, she became positively lesbian identified through the feminist movement of the late 1960s-1970s. All her romantic relationships were with women and she had had a number of monogamous pairings as an adult, although none had lasted more than 3 years. In fact, in her only acknowledgment of concern about her own sexuality, Cheryl admitted that she had encountered low sexual desire in her other partners but had always left the relationship without attempting to work out the sexual difficulties. Moreover, she expressed worry that her sex drive might be "too high" and that this made her "like my father," who had been a womanizer. Cheryl reported that sex was a primary outlet for her not only for intimacy but for tension, relief from boredom, and so on. She displayed clear negative judgments about Mickie's sexual style. She felt Mickie was "not spontaneous," "not capable of mutual sex," and too interested in sadomasochism and other atypical sexual acts. She deplored in general Cheryl's "slut mentality" toward sex.

The following hypotheses were generated after reading the women's questionnaires:

- That Mickie was in fact capable of being quite sexual but that her sexuality had become ego-dystonic not only because of guilt inculcated in her childhood but because of ongoing criticism of her sexuality by Cheryl.
- That Cheryl had, in a sense, too much “riding” on sex; she viewed sex as a panacea and relief for a variety of different frustrating feelings, and that this made low sexual activity much more problematic for her than it might have otherwise.
- That Cheryl’s high need for sex combined with her rigid views of what was sexually appropriate and inappropriate (basically, her sexuality was “right” and Mickie’s “wrong”) created overwhelming pressure on Mickie’s leading to insurmountable performance anxiety around sexual activity.
- That the two women had distinctly conflicting sexual styles/scripts.
- That both women had built up years of resentment about the sexual difficulties — Cheryl, because she felt she had been denied sex; Mickie, because she felt she was criticized and pressured for sex — that would be hard to diffuse.

The Course of Treatment

During session 2, these hypotheses were offered to Cheryl and Mickie. Two things were emphasized in this initial feedback session: the idea that Mickie might be inherently a sexual person but simply frightened of her own sexual desires and the concept that the stylistic conflicts between the women might be merely differences, rather than right and wrong. Mickie had a dramatic reaction to the first hypothesis; she cried in relief that there might be hope for her- to recover a joyful sexual expression. The second hypothesis drew a mixed response: Both women were somewhat disbelieving of the reframing of their differences as normal variations of sexual preferences. This was true not only because Cheryl had tapped into Mickie's underlying guilt about sex to convince her that her sexuality was wrong. It also

appeared that the couple was fused in a very special way. While they were capable of having some separateness in job friends, and other aspects of daily life, they were not capable of having different beliefs or values and respecting each other's beliefs as valid. At later points in treatment this problem came up repeatedly; the couple could never "agree to disagree," and all differences had to be argued until one conceded to the other. The women had other reactions to the hypotheses as well. Mickie, as might be expected, was heartened by the ideas while Cheryl was predictably suspicious of me. Because Cheryl saw her form of sexuality as "genuinely" lesbian and Mickie's as "male identified," my defense of Mickie was at first attributed to my bisexuality. About one third of this session was spent in dialogue between me and Cheryl in which I described the position of the lesbian sex radicals in order to support my view, quoting extensively from Pat Califia (1988), a controversial but impeccably lesbian writer and radical. Cheryl tentatively agreed to reserve judgment on the issue of sexual political correctness and the first sensate focus exercise was assigned as homework. The couple was asked to reserve 2 hours of "prime time" to be together and to use some of this time relaxing and setting the mood for intimacy. They were instructed to take turns as toucher and touchee and to engage in sensual stroking, avoiding contact with breasts and genitals.

Cheryl came to the next session angry. While Mickie had very much enjoyed and even been aroused by being touched, she had experienced conscious performance anxiety ("Am I doing this right? Will Cheryl be mad at me?") while touching Cheryl. Cheryl, on the other hand, initially was able to articulate only her criticisms of the exercise itself: Because sensate focus is by nature "my turn/your turn," and because Cheryl prefers mutuality, she felt the assignment of the exercise was a tacit disapproval of her preferences. Her anger was allayed somewhat by acknowledging the artificial nature of the exercise and explaining in more detail the reasons for its structure. Ultimately, Cheryl, who over the course of treatment displayed great capacity for self-awareness, was able to admit that she had been very uncomfortable being touched by Mickie because it made her anxious to receive pleasure without at the same time giving in return. As we explored this feeling, it emerged that Cheryl placed an enormous emphasis on her own ability to be a good lover and felt undeserving of a partner's total attention ("it's selfish"). In fact, it was her discomfort with purely receiving that probably made her so adamant about the necessity for sexual encounters to be completely mutual. Homework for session 4 was a sensate focus exercise with "guided touch," that is, with each woman guiding her partner's hand while being touched. In addition, the couple was asked to talk to each other after the sensate focus, using a couple dialogue they had learned in relationship counseling, and to express only their positive feelings to each other. This was done in part to begin to change a destructive aspect of their relationship. In the name of honesty, Mickie and Cheryl had a tendency to blurt out every negative feeling they had toward each other without reflection. I wanted to reinforce the idea that it was not necessarily "dishonest" to focus on positive feelings and keep some criticisms private.

At session 4, both women expressed some anxiety over being touched and guiding, although for different reasons. Mickie was concerned that her guiding of Cheryl would reveal "bad" sexual desires, and Cheryl became aware of a vague discomfort, although she was also surprised at how nurtured she could feel simply through nongenital touch. I was pleased at the latter because I hoped it would begin to teach Cheryl that she did not always need genital sex to feel intimacy. Both women were put in trance in this session so that they could explore the anxiety they felt during the homework more deeply; light hypnosis often allows clients to experience emotion

more vividly and to make connections not easily accessible in the fully awake state of consciousness. Cheryl emerged from trance in touch with her own feelings of unworthiness while Mickie was overcome with the terror she felt at being criticized by Cheryl. Both women related these fears to issues they had been exploring in their relationship counseling; Cheryl to her awareness of her role as caretaker and Mickie to her insight that criticism evoked a fear of abandonment in her. The women's homework for session 5 was to repeat the same exercise concentrating fully on receiving pleasure when they were being touched.

The women appeared at session 5 without having carried out their assignment. Cheryl reported that shortly after the last session, she had fallen into despair about the relationship and become consumed with thoughts of leaving. It was conjectured that perhaps she had gotten too close to areas of intense anxiety; Cheryl rejected this hypothesis. Little was resolved and the previous homework assignment was repeated. For the next few sessions, the women completed assignments without great resistance.

During sessions 6 through 9, conducted over 3 months, Cheryl and Mickie progressed through sensate focus exercises that included genital touching, alternating who would initiate the homework assignments. In treatment, a core power struggle issue emerged: the conflict over which woman would control the structure of the sexual encounters. As Mickie lost much of her performance anxiety and guilt about sex and became able to be approached as well as to initiate sex, Cheryl became increasingly aware of how vulnerable to hurt she felt when she did not have total control. In general, these sessions went smoothly with a high degree of insight in both women and few accusations between them.

The couple arrived at session 10 in high spirits. They had gone on vacation together and had sex several times. Although most often Mickie had initiated sex and the sex had been brief, somewhat rough, and sometimes one-sided, Cheryl reported that she had enjoyed the encounters and appeared to have become more flexible in her own sexual script. She did voice concern, however, that "this can't continue" and that she might be disappointed once again. Her expression of this worry frightened Mickie, who again voiced fears of "displeasing" Cheryl. In retrospect, the disaster that followed this session might have been avoided had a relapse been predicted.

Three weeks later the women reported no sexual activity and dissatisfaction with each other, but instead of discussing their conflicts turned on me and attacked my bisexuality. Because nothing fruitful was resolved in this session, another session was scheduled for I week later. No sexual contact had taken place but both women were able to acknowledge their fears about becoming more sexual, and they were "given permission" to go more slowly in their sexual relationship. Because Mickie still reported anxiety over whether her sexual desires were okay, they were invited to come up with private "wish lists" of sexual desires and fantasies and to bring them to the next session. Session 13 was spent in using the technique of couple dialogue for the partners to reveal and validate their sexual desires to each other. The pair continued to avoid sexual contact during this period, choosing not even to engage in the simplest sensate focus.

The couple produced another conflict that discouraged sexual intimacy during the next 6 weeks. Cheryl became outraged over Mickie's herpes, which Mickie had contracted before the two women met but which suddenly emerged as a reason why Cheryl feared sex with Mickie. Cheryl also revealed a deeper concern. She realized that even if she and Mickie succeeded in "reviving" their sex life, it was not going to

resemble her private fantasy. Cheryl spoke of her desires to have the kind of intense, passionate, spontaneous sexual experiences found only in the limerance phase of a relationship. She readily acknowledged that as she had left all previous relationships after I to 3 years, she had no realistic concept of what to expect from sex in a long-term relationship. Moreover, Cheryl was acutely experiencing a midlife crisis that involved feelings of loss and failure in all aspects of her life, especially her career. The recognition that a good sex life with Mickie might involve satisfying sex but was unlikely to include episodes of weak-kneed, overwhelming passion was deeply upsetting to Cheryl. Mickie, on the other hand, having always felt some guilt over sex and feeling now more sexually free than ever, experienced no such sense of loss. This left Cheryl feeling more alone.

In sessions 17 through 19, sensate focus was reintroduced and the two women gradually became more sexual with each other again, with a frequency of about once a week. Nevertheless, Cheryl's depression deepened and she was referred for antidepressant medication. After some sparring about why a lesbian psychiatrist could not be identified, Cheryl accepted the consultation and was placed on Paxil (paroxetine hydro-chloride).

The Paxil radically changed Cheryl. She attained a greater acceptance of her relationship with Mickie, both sexual and otherwise, with all its inherent flaws and imperfections. Most important, she became more accepting of herself. She likened this experience to experiences she had had in Tibetan monasteries, and she and I had some interesting conversations about Ram Dass, Buddhism, and accepting and enjoying "what is" in life rather than pining for what one cannot have. Over the next 4 months, follow-up sessions were conducted every 3 to 4 weeks. At termination, the couple enjoyed a regular and satisfying sexual relationship, although it was one that resembled Mickie's script more than Cheryl's "regular" script. That is, the couple had expanded their repertoire so that sex did not always have to be "equal" and mutual. Sometimes sexual encounters involved one woman pleasuring the other; sometimes sex was very brief; at times the women would engage in sensual foreplay and then bring themselves to orgasm in each other's presence with vibrators. In this couple's relationship, Cheryl had compromised more than Mickie, letting go of many cherished beliefs about how sex should be. It remains to be seen whether she will be satisfied in the long run, however, or whether she will ultimately decide to seek another partner whose sexual script more closely resembles her own. This may depend on the nonsexual aspects of their relationship. At this writing, the women are still receiving relationship counseling, and it is uncertain whether they can ever live together harmoniously enough to satisfy them both. Although the sex therapy was at least a partial success, it may not be enough to save the relationship.

Conclusions and Discussion

This case was typical of the kind of sexual issues presented by lesbian couples not only in the problem but also in interventions used and outcome. It was perhaps most atypical in the degree of suspicion the clients had of the therapist and their extreme politicization of sex. The case raises some interesting questions about lesbian sexuality and lesbian partnerships.

To begin with, the relatively low frequency of sex in long-term lesbian relationships should make us question our norms for sexual behavior. Although most of us like to think of ourselves as nonjudgmental about sex, of course, this cannot be true and all of us have an unconscious or minimally conscious set of expectations about what is "healthy" and "unhealthy," "normal" and "abnormal," and so on. But if, as almost all

research shows, universally males in Western industrialized societies are more sexually active than are females, it is probable that our expectations of normal frequency are skewed toward male desire, and probably heterosexual male desire as well. Most of us tend to assume that long-term relationships "should include" genital, orgasmic sexual contact, but in fact we have little understanding of the functions, other than procreative, served by sex in relationships and whether other behaviors would serve as well. We might look to the behavior of many male couples to get glimpses of other ways of being, as well as to the behavior of lesbian couples who do not come to therapy (MeWhirter 6c Mattison, 1984; Clunis & Green, 1988). For example, MeWhirter and Mattison report that before AIDS the norm for gay male couples was nonmonagamy, with perhaps less genital contact between the long-term partners than with their outside sexual contacts. Moreover, many urban gay men in the 1970s experimented widely with less common forms of sexuality: dominance and submission, bondage, manual-anal penetration (fist fucking"), sexual use of enemas and/or urine, as well as various types of group and public sex. These sexual techniques often deemphasized genital contact and orgasm. For example, much public S/M sex involves no oral or genital contact whatsoever, and orgasm is not the goal. And even after HIV greatly decreased gay male sexual activity, a new form of group sex emerged: the "J/O" ("jerk-off") party in which many men looked at and touched each other but brought themselves to orgasm through masturbation. Thus an urban gay male accustomed to sexual practices of the 1970s and 1980s might not define sexual contact in the same way as would a sex researcher or sex therapist or the average heterosexual. "Sex" between partners might consist of watching a porn movie together, touching each other a little, and self- or mutual masturbation. It is interesting to consider how such broadening of the definition of sex might affect sexuality in long-term couples—or how it might affect the technique and approach of sex therapists. Many lesbian couples seem to find that our genital-orgasm focus on sexuality does not fit their needs or practices. It may be that, for some couples, two or three satisfying genital-orgasmic contacts per year, lots of cuddling, and some masturbation might be perfectly sufficient for quality relating.

In fact, in many cases of low sexual frequency in lesbian couples, it becomes difficult to tell the source of the couples' dissatisfaction. The cultural feminist critique of sex therapy may have some merit, after all. Perhaps we should be working harder with couples such as Mickie and Cheryl to normalize less frequent sexual contact, to expand definitions of sex to include nongenital and/or nonorgasmic arousal, or self masturbation, as an orgasm technique. As sex therapists, we may need to do more psychoeducation to help our clients break free of unconscious heterosexist models of sexuality. This would benefit all clients, not just lesbians. For example, consider the heterosexual couple whose complain is that the women cannot reach orgasm through intercourse. For some couples, the wisest course of treatment might be to help free them from their intercourse focus and their belief that orgasms must be produce by their partner's efforts. Perhaps as sex therapists we should be more aggressive in challenging clients' requests for change. Most of us would automatically challenge a gay client who asked to change her sexual orientation. Perhaps we should also consider questioning the request of "increase desire," or at least stop accepting this therapeutic contract at face value.

References Blumstein, P., & Schwartz, P. (1983). American couples. New York: Morrow. Burch, B. (1987). Barriers to intimacy: Conflicts over power, dependency, and nurturing in lesbian relationships. In Boston Lesbian Psychologies Collective (Ed.), Lesbian psychologies: Explorations and challenges (pp. 126-142). Chicago:

University of Illinois Press. Califia, P. (1988). Macho sluts. Boston: Alyson. Clunis, D. M., & Green, G. D. (1988). Lesbian couples. Seattle: Seal Press. Colette (1930). The pure and the impure. New York: Farrar, Straus, &. Giroux. Dworkin, A. (1980). Why so-called radical men love and need pornography. In L. Lederer (Ed.), Take back the night: Women on pornography. New York: Morrow. Faderman, L. (1981). Surpassing the love of men: Romantic friendship and love between women from the Renaissance to the present. New York: Morrow. Faderman, L. (1991). Odd girls and twilight lovers: A history oflesbian life in twentieth-century America. New York: Columbia University Press. Huribert, D. F„ & Apt, C. (1993). Female sexuality: A comparative study between women in homosexual and heterosexual relationships. Journal of Sex and Marital Therapy, 19, 315-327. Loulan, J. (1985). Lesbian sex. San Francisco: Spinsters Ink. MeWhirter, D., & Mattison, A. (1984). The male couple. Englewood Cliffs, NJ: Prentice-Hall. Nichols, M. (1987). Lesbian sexuality: Issues and developing theory. In Boston Lesbian Psychologies Collective (Ed.), Lesbian psychologies: Explorations and challenges (pp. 97-125). Chicago: University of Illinois Press. Nichols, M. (1988). Low sex desire in lesbian couples. In S. R. Leiblum & R. C. Rosen (Eds.), Sexual desire disorders (pp. 387-411). New York: Guilford Press. Tripp, C. (1975). The homosexual matrix. New York: McGraw-Hill.