Margaret Nichols, Ph.D. Director

Sexual Function in Lesbians and Lesbian Relationships

Introduction Since the American Psychiatric Association officially de-classified homosexuality as a mental illness in 1973, most healthcare professionals have gradually accepted the view that being gay or lesbian is a sexual variation rather than a disease.

Many are also recognizing that gay patients often have unique needs and concerns. While most doctors and therapists have at least an occasional homosexual patient, some practitioners find that gays comprise a noticeable portion of their patient load. Gays are concentrated more heavily in urban areas (Laumann et al.,1994)and higher educational groups, and lesbian activity is common on college campuses (Diamond,2003b). Lesbians are heavy users of mental health services: a national survey of lesbian health (Ryan and Bradford,1993) showed that nearly three-quarters of respondents had at some point been in therapy or counseling, and two-thirds of this lesbian sample preferred female practitioners. So, for example, female gynecologists and sex therapists located near college campuses or in urban settings may find that a significant number of their patients are women who have sex with other women.

This chapter outlines some of the unique features of lesbian sex and lesbian sexual relationships that might concern the healthcare professional. The material presented here has been compiled from the relatively meager selection of research oriented towards lesbian sexuality, from the clinical experience of the author and colleagues who work with lesbian clients, and from an internet-based study of lesbian, bisexual, and heterosexual women's sexual behavior conducted in 2003-2004 at the Institute for Personal Growth, a psychotherapy center in New Jersey serving the gay, lesbian, and bisexual community. This latter data, collected by the author and her colleagues, will be referred to as IPG internet study results (Nichols, et al., 2004).

Sensitivity: the 'heterosexual assumption' Before discussing lesbian sexuality, it is worth noting that it is more important for a doctor or therapist to have an open, aware attitude towards lesbian patients than for that professional to have a wealth of knowledge about sexual minorities. Ryan and Bradford's lesbian health survey established that the single biggest complaint of the respondents was that health and mental health practitioners had an inherent heterosexual bias, an automatic assumption that everyone is 'straight.' These assumptions are usually unconscious. For example, when a gynecologist reflexively asks about birth control; when the office intake form asks for "marital status: single/married/divorced/widowed;" when the provider asks "are you sexually active?" and means "are you having heterosexual sexual intercourse," many lesbians will be offended and/or conclude that the provider is insensitive or prejudiced towards gays. In fact, Ryan and

Bradford found that so many lesbians are put off by the perceived insensitivity of their doctors that 17% would not even reveal their sexual orientation to their health care practitioner, even though that information might be critical for treatment. Thus the 'gay-affirmative' health care professional must approach each female patient as though she may have feelings, history, or current behavior that is homosexual. The provider must demonstrate openness to the possibility of female-female sexual experience in each woman in order to gain the trust of the lesbian patient.

Special features of lesbian sexuality Identity versus behavior; sexual fluidity In a culture that stigmatizes same-sex behavior, as ours still does, 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(Roberts et al.,2000)have found that the vast majority of self-identified lesbians - 80-90 per cent - have had at least one male sexual partner.

However, the reality is more complicated. Recent evidence suggests that women may be physiologically 'wired' for bisexuality (Chivers etal,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,2000a, Weise,1992). Diamond(2000b)found that a significant number of lesbian-identified college women change their self-labeling to bisexual or heterosexual over a five year period. Moreover, these women do not 'disavow' their former lesbian identity and are open to the possibility of sexual change in their futures.

The IPG internet study reveals an even more complex picture. 75% of the 231 self-identified lesbians had had one or more male sex partners, and 63% report sexual attractions to men; three of them were in relationships with men at the time they completed the survey. But 52% of the 132 self-identified heterosexual women reported sexual attractions to women, 22% had at least one female sexual partner, and one was currently in a relationship with a woman. If one were to define sexual orientation in terms of capacity for sexual attraction, the majority of these self-labeled lesbian and heterosexual women would technically be bisexual.

But bisexuality as a personal identity is a relatively new phenomenon, emerging only within the last twenty years of so (Nichols,1994; Weise,1992). And women who self-label as bisexual- as opposed to

those who simply exhibit bisexual attractions - may be a distinct and unique sub-group within what is now commonly known as the "LBGT (lesbian, bisexual, gay, and transgendered)" community. The IPG Internet Study found that the 152 survey respondents who self-labeled bisexual had some sexual behaviors that set them apart from either lesbian or heterosexual women. Bisexual women masturbated more ($p<.000$), thought about sex more ($p<.003$),and had nearly twice the number of lifetime sex partners than their gay or straight counterparts ($p<.02$). In addition, they were far more likely to also identify with the 'kink' community - women engaging in some form of dominance-submission sex play ($p<.001$) - and the 'polyamory' community - women with multiple concurrent sexual/relationship partners ($p<.000$).

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 must not make any assumptions about the sexual behavior of a client without the taking of a careful history that includes questions about contact with both men and women regardless of the patient's expressed identity.

Gender identity and 'gender bending' At the peak of the lesbian feminist movement in the 1970s, it was unacceptable to identify as 'butch' or 'femme;' androgyny was the only 'politically correct' choice. However, that has changed dramatically, so much so that female to male transsexuals are much more visible in the lesbian community (Bernstein, 2004; Levy,2004). Some of the established professional definitions of transsexualism are being challenged, as more and more women identify themselves as being part of the 'transgender continuum.' For example, 'trannie boys' are lesbians who take male hormones, may or may not have 'top surgery' on their breasts, and retain their female genitalia; 'bois' are gay women with completely female bodies who dress and comport themselves like men, use male pronouns to identify themselves, and often appear in public 'packing' - wearing a strap-on dildo under their pants. The IPG internet study allowed women to identify their gender as 'female' or 'other.' Five percent of lesbians identified as 'other' while virtually none of the bisexual or heterosexual women did so ($p<.000$). Asked to describe "other," these women used words like "transgendered," "gender queer," "butch" or "ftm." We also asked women to identify where they fell on a 'butch-femme' continuum, and while 26% of the lesbians labeled themselves 'butch,' only a handful of bisexual and heterosexual women did so ($p<.000$).

The phenomenon described above suggests it may be time for a paradigm shift in our concepts of gender identity and sexual orientation. For three decades both gay rights activists and sexuality experts have encouraged us to think that these two core self-concepts

are separate, in part because sexology was for a long time dominated by the social constructivist view that gender identity was socially constructed. Moreover, we have come to think of 'lesbianism' as a uniform sexual orientation, rather than as a label describing a broad range of behaviors and feelings. Increasingly, we are recognizing that there are substantial differences in sexual behavior among self-labeled lesbians: some women have never been attracted to men, others have strong attractions and history of involvement with men; for some the identity will be constant throughout their lifetime, for others it may be more fluid. We also notice the lesbian community itself returning to butch-femme dichotomies, but with new twists. Perhaps this means it is time to reconsider a biological basis at least for women who label themselves butch or bois, as well as for female-to-male transsexuals, who frequently have identified as lesbian before coming to a 'trans' identity. Some studies have shown that girls born with congenital adrenal hyperplasia have more male-typical behavior as children, more dissatisfaction with female sex role assignment, and less heterosexual interest than non-CAH girls (Hines et al. 2004). And at least one study of lesbians who identify as butch found that butches recalled more childhood gender-atypical behavior and had higher waist-to-hip ratios, higher saliva testosterone levels, and less desire to give birth than either femme lesbians or heterosexual women (Singh, et al. 1999). The IPG internet study found self-labeled 'butch' women to be less likely to be attracted to males ($p<.03$) than other lesbians but with no difference in their number of male partners.

For the healthcare provider working with lesbian patients, this implies a need to loosen rigid definitions of gender and to change the currently marked distinction between 'transsexuals' and 'everybody else.' In the future, the health care community may be forced to deal with, for example, women who ask their doctors for hormones without desiring to fully 'transition' to the opposite gender; it is not unrealistic to think that even the esteemed Harry Benjamin Standards of Care for transsexuals may need revision.

Sexually transmitted infections Despite scant research, some of the most consistent findings regarding lesbian sexuality have been in the area of STIs. Roberts et al (2000) reviewed ten studies, including their own, that all showed lesbians having fewer STIs than bisexual or heterosexual women. In particular, gonorrhea, syphilis, HIV, and hepatitis B are less common among lesbians, as are abnormal pap smears. The IPG internet study found significant differences in the total number of lifetime STIs between lesbian, bisexual, and heterosexual women, and a strong correlation ($p<.000$) between the total number of STIs and the total number of male sex partners. Looking at individual STIs (Figure 1), we found lower rates for lesbians for each STI, but the only significant difference for an individual STI

for the incidence of abnormal pap smears: lesbians had the lowest rates, then bisexuals, and heterosexual women had the most abnormal pap smears ($p<.01$). The data on abnormal pap smears corroborates the many studies that have shown nuns to have a low incidence of cervical cancer; the differentiating variable probably is the male penis and number of different male partners, not sexual activity alone.

It is important to note that although a number of studies show lesbians having fewer STIs than heterosexual women, that finding seems to be related to the number of male partners a woman has, and we know from a multitude of sources that most lesbians have had at least one male sex partner. This is yet another reason why there is no substitute for the taking of a detailed sexual history; one cannot rely upon self-identification alone.

The 'common knowledge' about lesbian relationships In 1983, the highly regarded book American Couples (Blumstein & Schwartz) compared heterosexual married, heterosexual cohabitating, gay male, and lesbian relationships and found lesbian couples to have the least frequent sexual contact. 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 1980's 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. Two explanations were often given for this phenomenon; internalized shame associated with homophobia, and the 'unmitigated female sexuality' of a two women together, i.e., a union in which both partners had relatively low sex drive, low sexual assertiveness, and a high degree of intimacy (Nichols, 1988,1990). Both lesbian and gay male relationships are often viewed as being shorter than heterosexual relationships, although Blumberg and Schwartz made it quite clear that in their study that longevity was related to legal marital status far more than sexual orientation, i.e., cohabitating heterosexual couples have relationships as short as gay and lesbian couples, and heterosexual married couples stay together significantly longer than any other type of partnership.

In recent years, some sexologists have criticized mainstream sexual theory as being phallocentric and heterosexist (Kaschak and Tiefer, 2001, Kleinplatz, 2001, Rothblum and Brehony, 1993). They have argued against the traditional definition of sex as genital contact directed towards orgasm and suggested an expansion to include mutual, sensual physical contact not focused on orgasm. Others 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.' From this point of view, sex therapy for a non-genitally sexual lesbian couple might include encouraging them to question why they feel a need to be sexual.

Some lesbian psychotherapists argue that 'lesbian bed death' is a myth based on insufficient data. Matthews et al (2003) found no differences in sexual frequency rates of heterosexual versus lesbian women. And Iazenza (1991) found lesbians to be more sexually arousable and more sexually assertive than heterosexual women.

Meanwhile, the lesbian community itself has become more sexual in the last two decades (Nichols, 2000; Bolonik, 2004). Lesbian-owned and oriented erotica magazines, sex toy stores, and erotic video companies have proliferated. Lesbian clubs like Meow Mix in New York advertise "Pussy Galore" and "I Love Pussy" nights and brag about the 'action' in the bathrooms. Lesbian 'kink' organizations exist in most major U.S. cities and polyamory is becoming more common as well (Munson & Stelbourn, 1999).

Results of IPG internet study Data from this study of 231 self-identified lesbians, 152 bisexual women, and 132 heterosexual women were analyzed two ways: by self-identified orientation and, for women currently in relationships, by whether the participant was involved with a woman or a man. First, like Blumberg and Schwartz(1983) we found lesbian relationships to be of shorter duration than heterosexual relationships - four years average compared to eight years ($p<.000$), but this difference disappeared when we compared only unmarried women. Looking at 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.

Our primary analyses compared women in relationships with other women versus women with men. 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. The presence of children was not a factor; there was no difference in the number of children living with women with women (ww's) versus women with men (wm's). 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.

Looking at other aspects of sexuality, the ww's 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, ww's were more likely to have orgasms during sex with their partner than were wm's 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). We found that the typical sex acts associated with orgasm for women (regardless of gender of partner) were kissing (p<.000), non-genital touching (.006),receiving oral sex (p<.000), digital-vaginal stimulation (.001), and the use of sex toys (p<.004). And of these acts, kissing (p<.000), non-genital touching (p<.01), digital-vaginal stimulation (p,.000) and use of toys (.000) were more likely to be practiced by women with other women than by women with men.

Lesbian relationships revisited If we incorporate new information about the lesbian community with the results of more recent research and theory about female sexuality, the picture is more complex than the old stereotype portrays. First, we see increased support for the idea that legal marriage is related to longevity of relationship, for better or worse. Second, 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 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 measured 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.

Assimilating this information can radically change the professional's paradigm of sexual relationship health. Perhaps we should stop asking so much about sexual frequency, and instead ask more about female orgasm and pleasure, about quality versus quantity.

Lesbian sexual dysfunction There is little non-clinical data on the nature of lesbian sexual dysfunction as compared to that of heterosexual women. Clinical data suggests 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). For the IPG internet study, we looked at both self-identified lesbians versus heterosexuals as well as women

currently in relationships with other women versus women with men, and found that both analyses showed lesbians/women with women reporting fewer sexual problems than heterosexuals or women with men ($p<.002$, $p<.001$).

Figure 2 shows percentages of the overall sample, lesbians, and heterosexual women as they reported sexual dysfunction, and for which problems there was a significant difference between the two groups. Figure 3 shows the same data broken down for women in relationships with other women versus women with men. 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. Many of the differences between groups were significant, and only one problem - feeling more desire than one's partner - was reported more frequently for lesbians/women with women, although not at a statistically significant level.

If lesbians have fewer sexual problems than heterosexual women, and only slightly less sex, how then can we account for clinical accounts of lesbian bed death? Several possibilities exist. First, it is possible that greater social acceptance of homosexuality over the last two decades has made lesbians feel less internalized shame and homophobia and therefore less self-imposed sexual repression - note that in the IPG sample fewer lesbians than heterosexual women felt guilty about sex. In other words, lesbian bed death may have been more common twenty years ago than it is now. Another explanation may lie in the high percentage of lesbians who participate in psychotherapy - clinicians may see a disproportionate amount of lesbian couples with sex problems, and lack of interest in sex is by far the most common sexual complaint of all women.

Summary and conclusions The sexual health professional who works with lesbian clients is rewarded with an broadened and enriched perspective on female sexuality in general. The provider must, as with all minority groups, be sensitive to and respect cultural differences in sexual expression. When one practices within the lesbian community, he or she must be comfortable with patients' sexual fluidity both in behavior and self-identification, as well as with a broader range of gender identity. STI's are less common among lesbians, and sexual dysfunction may be less common as well, although lesbians are highly likely to seek counseling when they do have problems.

Most importantly, the sexual behavior of women with other women is different from that of women with men, and probably more consonant with the attainment of female orgasm. Although lesbian couples appear to have sex less frequently than their heterosexual

counterparts, they have sex because both partners want to, they spend more time on sex, include more non-genital, non penis-oriented acts, and their sexual activity more frequently results in orgasm for both partners. Indeed, when questioning not only lesbians but heterosexual women about their sexual practices, the practitioner might do well to focus more closely on female sexual pleasure, and to consider quantity of sex less important than quality.

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Figure 1: Sexually transmitted infections/conditions: women who responded "yes" to "ever had this condition/infection?" Lesbian/bisexual/hetero women contrastedIPG Internet study: 231 lesbian, 152 bisexual women, 132 heterosexual women * significant at p<.01

Type of sexually transmitted infection/condition	**Lesbians %"yes"**	**Bisexual women %"yes"**	**Hetero women %"yes"**	***Total Sample %***
Herpes	5	11	9	*8*
Abnormal pap smear	13	20	25	*18**
Vaginitis	5	8	5	*6*
Chlamydia	4	8	6	*6*
HPV	6	10	11	*9*
PID	2	2	3	*2*
Gonorrhea	0	2	1	*1*
Syphilis	0	0	0	*0*
HIV	0	0	1	*0*
Hepatis	3	0	2	5

Figure 2: Sexual problems: women who responded 'yes' to "ever had this sexual problem more than occasionally?" Lesbians versus heterosexual women IPG Internet Study: 231 lesbians, 132 heterosexual women (bisexuals excluded)

Type of sexual problem	**Lesbians %"yes"**	**Heteros %"yes"**	**Total Sample %"yes"**	***Significance level p<***
No interest in sex	40	45	42	
Difficulty/unable to orgasm	29	41	33	*.02*
Pain with penetration	20	30	23	*.02*
Unable to be penetrated	6	5	6	
Persistent, unwanted arousal	10	17	13	*.04*
Trouble lubricating	19	13	31	*.000*
Sex possible, but not pleasurable	19	27	22	*.05*
Guilt about sex	16	24	19	*.04*
Anxiety about sex	29	32	30	
More desire than partner	36	28	33	
Less desire than partner	37	46	40	

Figure3: Sexual problems: women who responded "yes" to "ever had this sexual

problem more than occasionally?" Women currently in relationships with women versus women in relationships with men

Type of sexual problem	**Female-female %"yes"**	**Female-male %"yes"**	**Total Sample %"yes"**	***Significance level p<***
No interest in sex	39	51	44	*.02*
Difficulty/unable to orgasm	32	41	36	
Pain with penetration	22	34	28	*.02*
Unable to be penetrated	6	4	5	
Persistent, unwanted arousal	11	17	14	*.02*
Trouble lubricating	18	32	25	*.002*
Sex possible, but not pleasurable	20	32	26	*.008*
Guilt about sex	18	22	20	
Anxiety about sex	28	34	31	
More desire than partner	36	34	35	
Less desire than partner	39	52	45	*.008*

IPG Internet study: 205 women with women; 179 women with men