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***Sex Therapy with Gay, Lesbian, Bisexual,  
Transgendered, and "Kinky"***

## INTRODUCTION

All psychotherapy is bound by history and geography, and perhaps none is more constrained by these forces than counseling done with members of special subgroups of the culture at large. The therapist must interpret the client's personal experience through the lens of a social context that is different from and perhaps alien to his or her own. She must be an anthropologist and sociologist as well as a psychologist/therapist.

Many sex therapists are already accustomed to receiving referrals of lesbian and gay clients, and previous editions of this book included chapters designed to familiarize counselors with gay issues. However, as we enter the millenium, there is an increasing tendency for the gay and lesbian community to include within its boundaries bisexuals, transgendered people, and people who practice forbidden sex acts, especially the many varieties of dominant/submissive sex : those individuals that the mainstream of society considers "the garbage heap of sex and gender trash" (Califia, 1997.) Thus the updated version of this chapter reflects the growth and changes what many now call the "queer" community – a title change that emphasizes the non-mainstream element of all its members. Although this chapter primarily describes sexual minorities within a large urban/suburban setting, it is still relevant to more rural or mid-American locations. Eventually, New York and West Coast urban cultural phenomenon trickle out to the rest of the United States, at least within this community. And even individuals who do not consider themselves to be "members" of a sexual minority community cannot help but be influenced by its mores.

It is important to note that some gay people will take exception to my inclusion of bisexuals, transgenderists, and kinky- sex aficionados as members of "their" community. But I would argue that the affinity of these other sexual minorities for the lesbian and gay culture is not accidental. While breaking barriers of sexual orientation and gender roles does not necessarily mean that other taboos will be overcome, it does make such a result more likely. Moreover, there is considerable overlap of these different sexual minorities. In the last week, for example, I have done an intake on a lesbian couple who, as an aside, mentioned their extensive S/M experience, which includes public sex with multiple partners; talked to a colleague about a self-identified lesbian and gay man who have become romantically/sexually involved; and supervised a staff therapist working with a male-to-female lesbian transsexual.

There are problems inherent even in arriving at common definitions of sexual minorities, because the phenomenon we are attempting to define is so variable and complex. Let us take sexual preference as an example. We tend to think of sexual orientation as 1) a single phenomenon in which identity, behavior, and attractions are all consistent; 2) dichotomous( you're either gay or straight) or at most tripartite (gay,bi,heter); 3) unrelated to gender identity; and 3) stable throughout one's lifetime. In fact, it seems none of these things are true. Desire, behavior, and self-identification are not consistent within an individual: e.g., many people experience at least occasional same sex desire, while fewer demonstrate behavior and fewer still consider themselves to be gay ( Laumann, E., Gagnon,J., Michael,R., and Michaels, S., 1994). As Kinsey pointed out over fifty years ago, same-sex attractions exist along a continuum, and we superimpose discrete categories upon this continuum. The categories themselves are arbitrary and artificial, and vary with factors such as historical time period or who is applying the label. For example, probably most individuals with primary same-sex attraction and secondary heterosexual desire self-

label as "gay" if they are over thirty-five and "bisexual" if they are under twenty-five. Sexual orientation and gender identity seem to have more than a passing acquaintance, as any self-identified "butch" lesbian can explain ( Nestle, 1992). And while sexual identity is indeed stable and fixed for many, some individuals seem to have more fluid and changing orientation (McWhirter, D., Sanders, S. and Reinisch, J., 1990): the switch from lesbian to bisexual is so common that a Boston bisexual women's group calls itself the "Hasbians." For the most part, when terms like "gay" or "bisexual" are used here they refer to one's self-identification, but they may describe behavior or desire when discussing cases where clients themselves are confused about their orientation.

This chapter is written from what Jack Morin calls the "paradoxical perspective" of sex (Morin, 1997). Derived in part from the work of sexologist Robert Stoller( 1979)and philosopher Georges Bataille (1986) this paradigm eschews the pathology model as simplistic, thinly veiled moralism, and the "new sex therapy" approach as overly mechanistic and medical. In this model, sexuality is a set of phenomenon that are powerful, complex, multi-determined and multi-functional. Sex is part hard-wiring and part early environmental imprinting, with perhaps a few modifications along the way. But the "environmental influences" are nothing so simple as Oedipal complexes or even role models: the have their root in psychological attempts to deal with the terror and powerlessness inherent in childhood, among other things. 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 the "heterosexual imperative," 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 quite psychologically healthy, indeed brilliant, individuals. The community , particularly that which is concentrated in urban centers, validates and seems to encourage pushing the envelope of tradition. An illustration is the case of Martin, a thirty-eight year old academician, prestigious in his field and in many ways quite mainstream. When I first saw Martin in my office, he was married with two young children and a house in a quiet suburban community. After attaining tenure and approaching midlife, Martin took stock of his life and for the first time since early adolescence, started acting upon his homoerotic desires. Over a period of three years he finally, painfully extricated himself from his marriage while negotiating joint custody of his daughter and son, and ultimately partnered with another man with children. But Martin changed in other ways as well. He began to explore leather bars and dominant/submissive sexuality and played with what is sometimes called "gender bending" or "gender fuck" (Califia, 1994): a muscle tee shirt with a strand of pearls. He challenged his traditional concepts of relationship, negotiating with his partner a version of an "open relationship," sometimes called "modified monogamy" (Shernoff, 1999). In many ways, once Martin broke the gay taboo he was free to question many more of his beliefs and turned his brilliance to inventing an authentic and original life. In the queer community all stereotypes and beliefs about sex and gender are both confirmed and disconfirmed. 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. Some lesbians consider themselves "butches" or "femmes," but the "butch" may be the caretaker or she may be, as it is sometimes quipped, "butch in the streets and femme in the sheets." There are MTF

transgendered lesbians and support groups for gay male semen donors used by some lesbians desiring children. There are several lesbian-produced, lesbian-oriented porn magazines thriving for over a decade, an annual anthology of "best lesbian/bi women's written erotica", lesbian topless bars, and a lesbian S/M club sponsoring group "play parties" in every major urban center in the country.

From the paradoxical paradigm, the queer community has much to teach the mainstream. So this chapter has two goals: to help heterosexual sex therapists become better service providers for their sexual minority clients; and to give a glimpse of the rich information to be gleaned from a community that is a living laboratory for fearless sex and gender experiments.

**Psychological Issues And The Gay Community** Just as treatment of mainstream clients is dependent upon social trends and developments – e.g., the treatment of erectile dysfunction changed radically with the development of Viagra – the issues sexual minority clients bring to therapy depend upon their subcultural context. This section ties together history with psychological issues.

Psychotherapists working with sexual minorities should be aware that the very existence of these minorities is a recent cultural phenomenon. For example, the form homosexuality assumed in the last half century is somewhat unique. 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 life style, and a subculture (Boswell, 1980). Sexual minorities can be compared to racial or ethnic minorities, but this comparison is only partially accurate. Because sexual preferences are not usually passed from one generation to the next, gays and other subgroups cannot count on family-of-origin networks to help buttress them against prejudice or hostility from the mainstream culture. Moreover, gayness, unlike skin color but like many other aspects of sexuality, can be hidden, and thus individual gay people have the option of "passing" for straight with all the psychological issues attendant to that choice. 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.

**1969: The Beginnings of an Open Community** In its current visible form, the existence of the "gay community" can be dated from the 1969 "Stonewall Rebellion," a protest in Greenwich Village that marked the start of the "Gay Liberation Movement." Before the 1970s, there was a nearly universal consensus among Americans that homosexuality was an illness, a sin, or both. Gay people themselves shared this belief. Even the most self-accepting homosexuals saw themselves as inferior to the heterosexual mainstream. Before Stonewall the political efforts of homosexual groups centered on convincing society that homosexuality was a congenital disability for which the homosexual was blameless. Homosexuals never considered "coming out of the closet"; gay people did their best to "pass" for straight and suppress or at least hide their gay feelings. Moreover, it could be dangerous to act on one's gay attractions. Homosexuals could be jailed or committed to psychiatric institutions. Police raids on gay bars and other social gatherings were frequent, and those caught in the police net were ruined by the publicity attendant to the crackdowns (Katz, 1976).

Stonewall and Gay Liberation signaled a radical cultural change that began with the view homosexuals had of themselves. The liberation movement helped gays affirm the soundness and positive aspects of their orientation: "gay is good" became a

rallying cry just as "black is beautiful" had been in the 1960s. In urban areas of the country, gay people "came out" and built communities that could support them as families of origin often could not. Shame was replaced by pride. Most significantly, during the 1970s, gay men and lesbians "came out"—went public with their orientation—in ways that made it impossible for many Americans to dismiss homosexuality as something "out there" that happened to "others." Before Stonewall, information about homosexuality was scarce, and what did exist was uniformly negative. By the end of the 1970s, most Americans had been exposed to some version of the "gay and proud" theme, if only via watching gay people on television talk shows. Many had experienced a friend or family member "coming out" to them. Because of these cultural changes, gay people who were adolescents after 1970 usually seem more comfortable with their orientation and less psychologically scarred by their experiences than those born before the mid-1950s.

Gay men and lesbians developed their communities in quite different ways. Gay men clustered in large urban centers where they developed an almost quintessentially male culture, complete with hypermasculine appearance - short hair and moustaches, Levis and work boots. Many gay men viewed the freedom to have sex as a cornerstone of gayness. Even in the pro-sexual atmosphere of the 1970s, gay men had more sexual opportunities than anyone else—they could act on the traditional male fantasy (lots of sex, little commitment), unfettered by the traditional female fantasy (lots of intimacy and commitment) with which heterosexuals still had to contend.

When Bell and Weinberg (1978) published their study of gay men and lesbians in the San Francisco area, many people were shocked to learn that some gay men had had 500 to 1,000 different sexual partners during adulthood. But in fact, accumulating so many different partners was not too difficult for a gay man living in San Francisco in the 70s. With the abundance of bath houses and "back rooms" where sex might occur in "orgy" style, one man could have several different partners in one night. It would be a mistake to characterize this behavior as pathological, although certainly some few men did become compulsive sexual "addicts." Nor was this behavior a flight from intimacy. As McWhirter and Mattison (1984) point out in their groundbreaking book on gay couples, most gay men eventually formed committed partnerships that often lasted for long periods, a finding corroborated by Blumstein and Schwartz's (1983) study comparing gay, lesbian, and heterosexual couples. But gay men tended to couple in a manner distinctly geared to their life styles: most had mutually consensual nonmonogamous relationships.

Another aspect of gay male sexuality as it evolved in the 1970s was the development of "high-tech sex." Not only did gay men have more sex than anyone else, they also experimented with forms of sexuality previously associated only with fetishists. For example, Jay and Young (1979) report that 37% of gay men had experiences with sadomasochistic practices, 23% with "water sports" (urination), and 22% with "fist fucking" (insertion of hand into partner's anus). etc.). Sex therapists inexperienced with the gay male community often equate these practices with fetishism, but they lack the rigidity of what is ordinarily considered a fetish. Gay male sexuality in the 1970s pushed sexual boundaries and included a wide range of sometimes rather exotic sexual techniques.

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. Many lesbians seemed to see men—including gay men— as

oppressive, and if they acted politically, they were apt to do so in feminist or lesbian-only organizations rather than in a "gay rights" context. Often lesbians were interested in "reclaiming" areas of life—spirituality, history, family structure, the arts—that had been male dominated and that had ignored women's needs and voices. Not only was sex *not* the focus of lesbianism, it was actually quite a problematic issue.

In the 1970s (and to a lesser extent in the present) feminist interest in sexuality often focused on 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 stereotypic heterosexual sex was viewed automatically as "patriarchal," even when practiced by two women. Thus, many lesbians came to define as "politically incorrect" such behaviors as the attraction to or desire to wear "feminine" clothing or make-up; any sexual act that involved a more "active" and more "passive" partner; "rough" sex; fantasies involving domination/ submission or overpowerment; and sometimes even the desire to penetrate a partner or be penetrated oneself.

This attitude toward sex proved stifling for many women. To make matters worse, whereas gay men usually defined their orientation as a visceral sexual attraction over which they had no control, lesbians tended to define their orientation as a political or relationship choice and not necessarily an indication of where their exclusive or even strongest sexual attraction lay. Thus, some self-defined lesbians were in essence bisexual women who, for various reasons, choose not to act on their heterosexual sexual attractions. A great many of these women felt ashamed of their heterosexual fantasies or attractions, just as a primarily heterosexual person might feel frightened by his or her homosexual fantasies and attractions.

Clearly, gay male and lesbian life styles, behaviors, identities, and values evolved differently following the early gay liberation and feminist movements. But this changed radically in the 1980s because of two phenomena: the divergence of lesbianism from feminism; and the AIDS epidemic.

**The 80s: The Impact of HIV** In this country, AIDS was first noticed in the gay male community . As early as 1981, when the Centers for Disease Control called it "GRID" (Gay Related Immune Deficiency Syndrome), gay activists were debating the implications of this disease for the gay male community. At first, many gay men resisted the idea that HIV was communicated sexually; it was even believed that the "sexual communicability" concept was a government plot to undermine the gay male community (Shilts, ).

Within the gay community there was virulent debate about such things as shutting down gay bathhouses, a central source of multiple anonymous sexual encounters for gay men. As the death toll mounted, gay men became increasingly frightened and the community became more sexually conservative.

Within a few years, the kind of sexual activity that had previously seemed "liberating" and "life affirming" became a potential death sentence. As a consequence, in the 80s incidence of casual and anonymous sex among gay men dropped precipitously as venues of public sex one by one closed down. Sexual practices changed: anal sex became rare, oral sex was done with caution or condoms, and mutual masturbation gained primacy.

In part, AIDS had a profoundly negative impact on how gay men 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. The heterosexual community seemed to place blame upon gay men for AIDS ("You deserve this disease because you caused it by your sinful promiscuous behavior") and, not surprisingly, some gay men blamed themselves as well. An entire generation of young gay men had never experienced a time when sex was not deadly.

But most gay men responded to the challenge of AIDS with ingenious safer sex scripts. Thousands of men participated in safe sex workshops designed by their peers. AIDS prevention emphasized eroticizing safe sex as well as basics of transmission. New video and print pornography was produced to provide visual images of "hot" safe sex.

The gay male sexual norms developed in the 70s were modified but not destroyed in the 80s. Although the number of monogamous couples increased, a substantial number of male relationships remained nonexclusive. Bathhouses and back rooms were shut down for a time, but other private clubs emerged in which safe sex was the norm. For example, "jerk off" (J.O.) clubs proliferated, as did other private sex clubs where penetration was not allowed. Telephone sex became more widespread. Gay men greatly modified their sexual and relationship behavior, but never completely mimicked the heterosexual norm.

Meanwhile, lesbians became *more* interested in sex. During the 1980s the lesbian community fostered a sex radical movement that continues to grow and that is unparalleled by heterosexual women. The sex radicals included both lesbian and bisexual women and did much more than promote the joys of sex. They engaged in, described, and advertised sex that included activities considered outside the boundaries of "normal" female sexuality: rough sex, "dirty" sex, role-polarized sex, "promiscuity," anonymous sex, sex without love, and sadomasochistic sex.

By the mid-1980s, some women were producing pornographic magazines for lesbians and lesbian video porn that included scenes with dildoes, vaginal "fist fucking," and bondage and submission. Other lesbians created support organizations for women who enjoyed unusual or kinky sex. These groups met to demonstrate sexual techniques and to hold sex parties that ranged from "jill-off" events (modeled after "jack-off" clubs) to public forums for group sadomasochistic activities.

As the feminist influence within the lesbian community waned in the 1980s, many gay women shed the anti-male attitudes that had helped contribute to lesbians and gay men forming, for the most part, separate communities. In addition, lesbians responded to illness in their gay male brothers in noteworthy ways: in some areas of the country, lesbians actually formed a greater part of the community caregiving system for people with AIDs than did gay men. This brought lesbians and gay men into intimate contact. The so-called "lesbian baby boom" that started towards the end of the 1980s also helped to break down barriers: as many lesbians began to raise little boys, they bonded with gay men in order to provide role models and "uncles" for their children.

During the 80s and early 90s a "bisexual pride" movement began within the gay community. Most people view bisexuality with suspicion. Frequently, gays and

lesbians see the bisexual as a gay person who is too afraid to "come out." Sometimes this has been the case: the gay community abounds with stories of men and women who use the bisexual label in order to avoid facing their homosexual attractions. But in recent years the scientific discourse about bisexuality has increased (Klein & Wolf, 1985), as has the publication of personal testimonials (Bi any other name). As knowledge increases and prejudice softens, more bisexuals feel comfortable being open about their orientation. Although bisexuality is stigmatized within both the gay and heterosexual community, most self-identified bisexuals now consider themselves part of the gay community and feel more tolerance from gays and lesbians than from heterosexuals. Moreover, by the end of the 1990s acceptance had increased enough so that most gay organizations now identify themselves as "gay, lesbian, and bisexual."

In addition, the 90s saw the inclusion of transgendered people, particularly those with bisexual or gay sexual attractions, within the gay community. The traditional categories of "transsexual" versus "transvestite" seem to have largely been abandoned in favor of an array of gender/orientation variations that ranges from post-operative transsexuals who self-define as homosexual to "he/shes"- men who retain their penises but dress as females and take hormones to increase breast size and change secondary sex characteristics.

The last trend that emerged in the 1980s was the change in the style of gay political action. Many gay people believed that the United States government engaged in deliberate non-response to HIV and thus passively encouraged the devastation of an entire generation of gay men. Enraged and cynical, some AIDS activists eschewed orderly marches and legislative reform in favor of more militant tactics, akin to the tactics used in the anti-Vietnam movement. ACT UP, one such group, specialized in clever and highly newsworthy civil disobedience actions and enjoyed widespread support during its existence. With ACT UP, gay politics came full circle from the pre-Stonewall days, when homosexuals asked nicely for tolerance for their "disability." Now, gays used in-your-face tactics to show their rage against a power structure perceived as willfully allowing gay men to die.

**The 90s and Beyond: the Emergence of the Queer Nation** In the community that came to describe itself as "lesbian, gay, bisexual, and transgendered," the last decade of the century was characterized by increasing social acceptance, continued breakdown of sex and gender categories, expanding diversity of lifestyle, and a "role reversal" in sexual attitudes of men and women.

For any gay person born in the "baby boom" generation or before, the acculturation of homosexuals into the heterosexual community seems to have proceeded at warp speed. Within only thirty years, same-sex lifestyle and identity became visible instead of hidden, and tolerated (if not accepted) by most Americans. It has become possible for even those whose career is in the public eye - congresspeople, entertainment celebrities - to increasingly "come out." Corporate America, quick to seize upon opportunity, has addressed major ad campaigns to gays, especially gay men, whose household income is the highest of any group in the country. By the turn of the century, Ikea Furniture had run television ads featuring same sex couples, Absolut Vodka is a staple ad of all gay magazines, and Ellen de Generis "came out" on prime time TV. In some ways, the lesbian and gay lifestyle has lost its "edge" and become assimilated. But this is only superficially true. In fact, the community has greatly expanded its diversity.

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. This appears to be particularly common within the lesbian community – for example, a support group of bisexual women in the Northeast calls itself the "Hasbians." The increase in self-acknowledged bisexuality has gone hand in hand with increased tolerance from the gay community:

For a long time, I was afraid to say I was bisexual, because it was largely regarded as a term for a lesbian who didn't want to "fess up" and I knew women who were like this and who used the term this way. I've only started calling myself "bisexual" in the last five years because the term seems to have lost the "closed lesbian" connotation. (Beemyn & Eliason, 1996,p.73)

At the Institute for Personal Growth, the agency I founded and direct which has worked intensively with a gay population since 1979, the populations of clients has increasingly included bisexual women who previously identified as lesbian but still consider themselves part of the gay community. Alison, for example, came to IPG in 1981 with her partner of ten years for couple counseling. At that time, both Alison and Marcia, her lover, were lesbian-feminist activists raising a son Marcia had given birth to in a previous heterosexual marriage. In 1997 Alison returned for help grieving the loss of her relationship with Joseph, with whom she connected after breaking up with Marcia. Alison continued to act as a parent to the boy she and Marcia had raised together- she helped pay for Jason's college education and had recently bought him a car. She identified as bisexual and held a position as treasurer for a large New York City support group for lesbian/bi women interested in S/M sex.

Because prejudice against bisexuality has waned within the community, men and women "coming out" now seem to have less conflict self-labeling as bisexual. Cindy, a student at a nearby university, identified herself as a "lesbian bisexual" when she first sought treatment for depression. Most of her sexual and romantic partners were female, but she sometimes had casual sex with men – usually bisexual men- and on one occasion felt she had fallen in love with a man. Unlike her counterparts from earlier decades, Cindy had no anxiety about her identity, did not fear exclusion from her community, and did not see her behavior or feelings as contradictory. Martin, the man mentioned earlier, could easily acknowledge his attractions to women and inherent bisexuality despite taking on a gay male identity. Even a decade earlier this would have been difficult; a man in a similar situation might feel pressured to hide his attraction to his former wife.

Similarly, gender categories are breaking down and becoming more ambiguous, and the categories of "homosexual" and "transgendered" overlap more and more. In the lesbian community, a subgroup of women label themselves as "butch" or "femme" (Nestle, 1992). "Radical Fairies" is a group of gay men who see cross-dressing in political terms. Once again, many younger lesbians and gays take gender ambiguity – sometimes called "gender fuck" or "gender bending" for granted:

"My gender identity is as fluid as the rest of me... I am a 24-year old woman who also identifies as a teenage boy." (Bernstein and Silberman,1996,p.221).

Some transsexuals now challenge the two-gender model as well. Kate Bornstein (1994), a male -to- female lesbian transsexual considers herself a third gender, not a "woman trapped in a male body." Her stance is radical: "One answer to the question 'Who is a transsexual?' might well be: 'Anyone who admits it.' A more political answer might be: 'Anyone whose performance of gender calls into question the construct of gender itself'." (Bornstein, 1994, p.121)

The breakdowns of gender are evident in interesting ways. Peter, a transgender client recently seen at IPG, was helped in therapy to recognize that his gender identity seemed to be changing in unpredictable ways over time, and he learned to resist the temptation to push himself into a bad fit with either gender category. At the time he left therapy, he dressed as a woman a substantial part of the time, had recognized attractions to men as well as to women, and felt that for the moment he did not want to go further with sex hormones or surgery, although he left that option open for the future. Claire, a postoperative male-to-female transsexual, also recognized her attractions to women after surgery and when she left therapy was partnered with another bisexual (genetic) female. Daniel, a bisexual man in a nonmonogamous marriage to a bisexual woman, came for treatment with questions about gender identity. Eventually Daniel recognized that his "gender-switch" needs were circumscribed: he enjoyed cross-dressing within the privacy of his home and enjoyed sex with men, but not with women, while cross-dressed. Another client, Genevieve, found the butch-femme movement a godsend. Her attractions were only to feminine women, and for years she had "felt like a man" and agonized about sex reassignment surgery. Joining a "butch support group" helped her validate her internal experience; she found she no longer felt a need for anatomical change.

An unusually striking example of gender attitude shifts is the case of Lisa, who first sought therapy at IPG in the early 1980s. At the age of twenty-two Lisa identified as a radical/separatist/lesbian/feminist," and sought help in controlling her rage at men, which was getting in the way of employment. In 1997 IPG received a call from Lee – who identified himself as the former Lisa, and was now a transsexual male who had undergone double mastectomy but still retained female genitals.

In the 1990s many lesbians and gay men made more "traditional" life choices. There was a large increase in the number of gay men raising children, primarily through adoption or co-parenting with lesbians, and a growing trend for gay men to create communities in small towns, where the lifestyle is more couple-and-family oriented and less sexual (Signorile, 1997). The proliferation of parenting options available to infertile heterosexuals has also filtered to the gay community. For example, Richard, a single gay man in his early 40s, recently became the father of a boy carried by a surrogate mother with Richard's sperm and an egg donated by a close female friend with children of her own.

The phenomenon of lesbians choosing motherhood has become so common that younger women "coming out" seem to see motherhood as an option to nearly the same degree as do heterosexual women. Lesbian and bisexual women climb the corporate ladder – they are sometimes called "execudykes" – spend money on clothes and makeup, balance home and career in much the same way as do heterosexual women – except that, unlike heterosexual women, they have partners who tend to share housework and childrearing equally. Both lesbians and gay men are united in a strong movement to obtain the right to legally marry.

Within the lesbian community, the 1990s has marked the emergence of an ethos of diversity and respect for individual difference that stands in sharp contrast to earlier years in which "personal is political" seemed to mean "there is only one correct way to live." Thus the explosion of lesbians choosing motherhood has been matched by an explosion of lesbians choosing lusty sexual expression.

In San Francisco today, the hottest lesbian club hosts a once-a-week splash that unabashedly features go-go dancers on pedestals and patrons clad in leather miniskirts. Across town sixty or seventy women gather to discuss the legal ins and

outs of donor insemination, foster adoption programs, power of attorney contracts, and parenting... There are many other signs of lesbian life... but few seem to capture the spirit of the moment so completely as femmes strutting around in their lipstick and high heels and the prospective mothers worrying about the quality of the school system.

Lesbian sexual styles are developing quite differently from what mainstream culture has come to think of as "women's sexuality," usually translated as romantic, gentle, sensual sexual expression. The emerging lesbian sexual scene has been influenced more by gay men than heterosexual women. With organizations with names like Lesbian Sex Mafia, bars named Clit Club, magazines named On Our Backs, Bad Attitude, and Cunt, lesbians "are moving beyond the realm of Sisterhood into the world of the nasty, the sexy, and the tasty. We are pushing the boundaries of what is acceptable lesbianism. We use the word "fuck" like the boys used to, we wear lipstick, we lust openly and pridefully (Stein,p.48) ...fuck, suck, clit, cunt. These are the words of our sex, and these are the words of our empowerment." (Stein, 1993, xi, p.88)

As the lesbian community seems to have become more respectful of individual sexual freedom, the gay male community is engaged in bitter controversy about sex. By the end of the first decade of HIV, the rate of new infection in the gay male population had dropped to nearly zero. While new infection rates continue to be low, in recent years the 70s-style hedonistic lifestyle reemerged among urban middle class gay males in the form of a series of huge all- night dance parties, held at varying locations and thus called "the circuit." Ironically, these parties are sometimes fund raisers for AIDS organizations. They are distinguished by enormous amounts of both drugs and sex. Symbolic of the controversy about circuit parties was the announcement in 1999 by the New York City Gay Men's Health Crisis, the world's largest HIV service organization, that it would no longer hold its annual "Morning Party" fundraiser on the Fire Island Pines, because in recent years it had been the site of several drug overdoses and numerous alleged incidents of unsafe sex.

Even more controversial than circuit parties is the recent phenomenon in urban gay male communities that is called "barebacking" – the reemergence of anal sex without use of condoms. What is unusual is that there are public advocates of 'barebacking' and a vigorous public discourse (Gendin, 1999; Scarce, 1999). Barebackers and their supporters regard the promoters of safe sex, from the Centers for Disease Control to AIDS prevention workers in the gay community, as "condom nazis" whose messages are erotophobic and hypocritical. They point out that many safe sex edicts are rational on the surface but moralistic in essence (Browning, 1994). For example, three commonly cited sex safe "rules" are: 1)reduce the overall number of your sexual partners; 2) avoid anal sex, especially anal sex without a condom, under all circumstances; 3) eliminate "fisting" (anal penetration by the hand) and "rimming"(analingus) entirely.

The most common route of sexual transmission of HIV, passive vaginal sex is also a common route and yet heterosexuals were never warned to "avoid vaginal sex." Moreover, the "never without a condom" rule is unnecessary between two monogamous partners with the same HIV status. Finally, "fisting" and "rimming" are most definitely not routes of transmission of HIV; their inclusion as "unsafe acts" is barely veiled moral repugnancy.

Proponents of barebacking feel, with some justification, that HIV ushered in an era where sex-negative, homophobic attitudes became validated. They take a harm-

reduction view of prevention, reasoning that no sex is entirely "safe" from various risks. They value sex as part of gay male identity; some see sex as a path to spiritual union. The public champions of "barebacking" advocate certain rules for containing risk and providing information needed to make responsible, consensual decisions. For example, most barebacking parties follow one of two scripts: they are either limited to only HIV positive men, or they require HIV positive men to identify themselves publicly and only "bareback" in the anal receptive position , which carries less transmission risk than anal insertive.

The emergency of "barebacking" may in part stem from changes in the treatment of HIV. In the mid-nineties new medications – protease inhibitors in combination with older drugs – have transformed HIV from an always-fatal illness to one that for many is instead a lifetime disability. The impact of this has been too enormous to describe fully here, but two trends stand out. A large number of men who had literally prepared for death – cashed in their life insurance to viatical companies, made no preparations for the future, refrained from establishing intimate relationships – suddenly became nearly well. With this reprieve came unexpected psychological and practical difficulties that have been labeled the "Lazarus syndrome" ( Ragaza, 1999).

A recent couples therapy case at IPG exemplifies this phenomenon. Victor and Howard were a HIV discordant couple who had been together for five years when the new medications came on the market. Howard, the HIV infected partner, responded dramatically to these drugs. Both men were forced to look closely at a relationship that both had assumed would end within a few more years. As a consequence of the "Lazarus syndrome," the couple broke up,. Victor, the HIV negative partner, had felt obligated to remain with Howard to take care of him while he died, and Howard was afraid to die alone. Once death was no longer an imminent possibility, both men realized that they did not have enough in common to sustain a relationship that might last decades .

Second, the emergence of AIDS in the 1980's and the transformation of the disease from a certain death sentence to a longterm illness fifteen years later has created sharply defined generational differences within the gay and lesbian community. While the "baby boom" generation of gays and lesbians has lost unprecedented numbers of peers to early death, and the generation of gay men under thirty-five never knew a time when sex was "safe," the youngest members of the gay community have never known a gay person who died of AIDS!

Some fear that these rapid changes may result in a higher rate of seroconversion among young gay men. This week a young lesbian cried in my office because her 27-year old gay male brother had just tested seropositive for HIV – after testing negative four months ago. The brother contracted HIV from a male sex partner who lied about his serostatus. Ten years ago few gay men would have considered having anal receptive unprotected sex with anyone but a long-term, committed lover – and then they took the test and were given results together!

The rapid and dramatic changes in the gay community in the last thirty years of the twentieth century have produced a phenomenon familiar to heterosexuals: a generation gap. Non- heterosexual men and women born after 1970 "came out," for the most part, during or after the development of AIDS activism. They often differentiate themselves sharply from older gays by calling themselves "queer," just as young black urban men use the term "nigga" in part to de-fuse the power of an epithet of bigotry and in part to distinguish themselves from their community elders.

"The term 'queer' emphasizes the blurring of identities... the queer movement/community was founded on principles of inclusivity and flexibility." (Beemyn & Eliason, 1996, p. 170)

The word "queer" breaks down boundaries among microcommunities (lesbians, gay men, bisexuals, transgendered people, fags, dykes, perverts) and gives us a united queer community...

(Bernstein & Silberman, 1996, xviii)

"Generation Q" feels alienated from older gays and lesbians. Myers-Parelli, a young lesbian, discusses her coming out to her parents.

When a lesbian comes out, the books read, parents are supposed to faint/cry/scream/disown you/deny/argue. But all mine said was "So?" If my coming out was not following the course that other lesbians had charted, I wondered, then how much of the rest of my life would their experiences apply to? (Bernstein & Silberman, 1996, p.213)

### **Issues And Cases In Sex Therapy**

Sex therapy with "queer clients" is not so different from sex therapy with straight clients except insofar as issues of sexual identity, alternative life styles and more "kinky" sexual practices may become the focus of treatment. Case vignettes will be offered to highlight some of the kinds of problems and issues that arise in work with these diverse and intriguing clients.

At IPG we find it useful to ask questions in the assessment phase of treatment that are not asked of heterosexual clients (see Appendix). These questions yield valuable information about, for example, the degree to which the individual may feel confusion or self-hatred about their sexuality and whether there may elements of their gender or sexual identity that may be ego-dystonic. Gay men who were "sissy" boys often have been deeply damaged by the reactions of others to them in childhood; both lesbians and gay men may be troubled if their fantasies and/or attractions do not match their self-labeling.

There are some sexual problems that therapists are more or less likely to see in the lesbian and gay male population than among heterosexual clients. Vaginismus and dyspareunia are almost never complaints for lesbians; women who experience these difficulties tend to avoid penetrative sex. Delayed ejaculation does not trouble gay men as frequently as straight men: many gay men include in their repertoires an acceptance of masturbation as a way to "end" a sexual encounter. Aversion to oral sex, on the other hand, is a very common complaint. Especially since HIV made anal sex taboo for many gay males, oral sex is often as important a sexual act for gay men and women as vaginal penetration is for heterosexuals.

Therapists who work with gay, lesbian, and heterosexual couples are often struck by the absence of gender-specific roles among gay and lesbian couples. Even in couples where the 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 enjoys children and keeping house, whereas the woman who loves lipstick and high heels may also be the one who does household plumbing repairs. Most importantly, 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 more traditional heterosexual marriages.

However, even if roles in same-sex relationships tend to be a bit more variable and fluid, roles in the bedroom may be rigidified. This problem is a bit easier to deal with in same-sex couples. For one thing, same-sex partners are not dealing with opposing sexual role expectations (e.g., male must initiate, female must be submissive) as are heterosexual partners. 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. Lesbians, and especially gay men, often have a knowledge of sexual technique that may surpass that of the therapist, and because there is nothing in gay sex comparable to the heterosexual emphasis on vaginal intercourse, they may be more willing to experiment with new sexual approaches.

Gay male couples (and some lesbian couples) often have sexually nonexclusive relationships. Both men and women in gay relationships sometimes request help in conducting nonmonogamous relationships within the context of a primary commitment to one partner. In these cases most nongay therapists have to examine their own beliefs about nonmonogamy. Most people, including sex therapists, are raised to regard nonmonogamy as sinful or destructive and are reluctant to acknowledge that sexual openness can work quite well for many couples provided that conflicts arising from jealousy and other issues are adequately anticipated and addressed.

The therapist can help the couple construct "rules of conduct" for nonmonogamy that will minimize pain and strife, and when nonmonogamy works it often actually enhances the sexual relationship of the primary partners.

### **Case Examples:**

With the aid of a counselor, Joe and Harold, monogamous partners for 2 years, negotiated a transition to nonmonogamy that began with joint expeditions to J.O. parties, moved to "three-ways," and eventually permitted both Joe and Harold to have independent sexual contacts provided that these contacts were "one-night stands."

Sally and Jessica were in conflict because Sally felt unable to commit to monogamy, and Jessica was doubtful about her ability to handle her jealousy. In therapy, the two women negotiated an agreement in which Sally was permitted outside affairs as long as Jessica never knew about them; that is, Sally could not see women who were mutual acquaintances and must conduct her affairs so that Jessica would not find out.

Nonmonogamy tends to be more common among gay male couples and also tends to be more successful. In large part, this is because gay men (like their heterosexual counterparts) can often separate sex and love quite easily and are satisfied with extramarital encounters that are purely sexual. By contrast, lesbians (like most women) fuse sex and love and tend to want not casual sexual encounters but "affairs" that are potentially more threatening to the primary relationship.

Just as nonmonogamy is a common issue for many gay male couples, lesbian

couples often suffer from fusion or the existence of such intense closeness and intimacy that the individual identities of the two women become completely submerged in the couple (Nichols, 1990,1988). Fusion is often an underlying cause of inhibited sexual desire in lesbian couples, the most frequent sexual complaint among gay women. Female couples tend to have less frequent sex than either heterosexuals or gay men (Blumstein & Schwartz, 1983). Frequently, this is not a problem, and many lesbian couples eventually cease having sex or have it rather rarely – a few times per year, for example. But when one woman has a lusty sexual appetite, there are problems.

The sex therapist sometimes has access to special resources less available in the heterosexual world. Among gay men paying for sex is so acceptable that quasi-surrogates are easily available. And lesbian erotica is so much more varied and abundant than that available to heterosexual women that a sex therapist can easily recommend a wide range of videos, magazines, and books with specific sexual variations – butch/femme sex, for example, or any of a wide variety of s/m practices.

### **Identity and "Coming out" Problems**

The number of individuals seeking treatment because they are confused about their sexual orientation or because they wish to change orientation has declined dramatically in the last several decades. Consequently, the *meaning* of identity confusion is different now. 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, 1995,1990). 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 dramatically. When clients present with severe sexual orientation confusion or self-hatred related to sexual identity, it is often symptomatic of deeper pathology.

### **Case Example:**

When Herb, a forty-four year old white male computer programmer, came to our practice complained of severe depression, his first words were "I'm not entirely sure I'm heterosexual." Herb still lives with his aging parents and has never lived independently except for his undergraduate college years. He has had one sexual experience with a woman, which was practically coerced by the woman, and none with males. He masturbates two or three times a week and his masturbation fantasies are entirely homosexual. Herb is conscious of sexual attractions to males, which he describes as "an unnatural preoccupation with the male body." He admires women but has no experience of being sexually aroused by a woman. He "cannot imagine" being gay, despite the fact that his mother and several friends have gone out of their way to express acceptance of homosexuality, and despite working in a corporation that has had an explicit policy of gay non-discrimination for many years and has recently introduced domestic partner benefits.

Twenty years ago Herb's story was commonplace. In 1999 it is highly unusual. Therefore, we considered Herb's struggle with sexual identity as symptomatic of a deeper, entrenched problem and diagnosed him with avoidant personality disorder. Our treatment goal is the same as it would have been with this presenting problem twenty years ago: to help him accept his gay orientation. However, we expect Herb's process to be longer and more difficult, and assume that a lack of social skills and

entrenched problems with intimacy will affect the course of treatment.

Herb's situation also reflects the continued existence of homophobia in the treatment biases of some heterosexual therapists. Before coming to IPG, Herb spent fifteen years in therapy with two different heterosexual male therapists. Neither one made sexual orientation a focus of treatment, despite Herb's report that he gave the same information to these previous therapists that he gave to us. One of them avoided discussion of sexual identity completely; the other told Herb that he "did not have enough sexual experience" to determine his sexual orientation. These therapists may have colluded with Herb's avoidant behavior in a way that has left Herb isolated and fearful of what will happen to him when his parents die – a realistic concern.

### **Case Example:**

The case of June is a less serious example of how the meaning of sexual identity confusion has changed over the last several decades.

June came for help in 1996, when she was twenty-two. Like Herb, June still lived with her parents and had limited sexual experience. However, unlike Herb, June did not masturbate at all, much less masturbate to homosexual fantasy. This is not uncommon among gay women, just as women, no matter what their sexual orientation, tend to have diminished sexuality as compared to men in all areas.

The only clue to her sexuality lay in her "friendships" with other women. Several of these relationships followed the same pattern: June became so intensely involved that her life revolved around the friendship, and she became broken-hearted when the "friend" eventually became involved in a love relationship with someone else. Most recently, these "friendships" had been with self-identified lesbians.

During the course of therapy June admitted to herself that her attractions had been romantic. She was given "homework" to learn to masturbate, and in the course of learning to pleasure herself she was asked to read books of women's sexual fantasies in order to discover what turned her on. Not surprisingly, she found the lesbian fantasies most erotic. It was difficult to determine why June's sexuality had been apparently repressed for so long. She came from a politically liberal, not particularly religious family and had always lived in the New York metropolitan area, where she had abundant exposure to gay lifestyles. She was not aware of homophobic feelings and attitudes and not particularly fearful of losing family or friends if she "came out."

As treatment continued it appeared that June's "repression" was more connected to issues of independence, intimacy, and lack of social skills than to "internalized homophobia." June had great difficulty with the idea of breaking from her parents to become an autonomous adult. She was also afraid of rejection and lacked assertive abilities. Thus, even when she was more certain she "might be gay," she found it almost impossible to make her attractions obvious to the object of her desire. Although, with prodding, she joined some gay groups and developed a network of lesbian acquaintances, her relationships with women never went beyond friendship. In fact, the only shift in her object choice was that as her same-sex desires became more obvious to her, she tended to develop infatuations with lesbians already in relationships. She became the "third wheel" of these relationships, the friend who tagged along with the couple when they allowed it. June left treatment without having a sexual experience, let alone a relationship. She was, however, much clearer about her barriers to intimacy. "I'm just the kind of person who has to move slowly,"



she said as treatment ended. "Maybe in a few years I'll be in a relationship." In a case such as this, June's identity confusion was akin to a red herring, masking deeper problems.

Because the mainstream culture is more accepting of homosexuality, gay lifestyles are much more visible than they were only a few short years ago: the existence of openly gay celebrities such as Ellen de Generis and, yes, Melissa Etheridge was unthinkable to previous generations. Therefore, it is more common for young people to question their identity even if they are *not* gay. As recently as twenty years ago a therapist could assume that a reasonably healthy client exhibiting sexual identity confusion was very likely to be gay or at least strongly bisexual. This is no longer true.

Tony came to therapy during his undergraduate years because in high school he had had sexual contact with a male teacher over an extended period of time. Tony was ashamed of this relationship and had kept it hidden from his male friends and his girlfriends. Although Tony himself raised the question of whether he might be gay, his relationship with the teacher appeared to have more to do with a need for male nurturing than with sexuality. Tony was always the recipient of touching or oral sex in these encounters and, although he became aroused to orgasm, he seemed to do so in spite of the same sex nature of the encounters rather than because of it. He reported no same sex fantasies, attractions, or behaviors either before or after his relationship with the older man.

Tony's attitude toward his sexual identity was striking in that he seemed comparatively undisturbed by the prospect of being gay or bisexual. "I'd rather be straight," he said. "But if I am gay, I want to find out now so I don't waste my life pretending to be something I am not."

After eight months of treatment Tony was able to let go of the disturbing feelings and memories associated with the past. He told his girlfriend, his mother, and eventually even some male friends about his experience. For a time he attended meetings of a support group for men who had been sexually abused as children. We both concluded that Tony probably was not "repressing his true feelings." Occasionally things are what they seem to be on the surface.

Sometimes the new openness about sexual orientation, especially on college campuses, creates new kinds of "coming out" problems.

### **Case Example:**

Claire was a young college student who saw me intermittently over a period of three years as part of treatment for her recurrent depressive disorder. When Claire was a psychology undergraduate student, she was an "out" activist for gay and women's causes, and experienced few reprisals for her openness from other students or faculty. After college Claire decided to get some field experience before continuing graduate work to become a psychotherapist, so she obtained a job as an aide on the adolescent unit of a nearby private psychiatric hospital. She was shocked to discover that her openness met with virulent disapproval from staff social workers. Claire was "out" to the adolescents in her care, and as a result several of them revealed their homosexuality to her. Her openness was labeled "inappropriate" by her superiors and she was faulted for "disrupting the treatment process" of the teens on her unit. Eventually, she was unjustly accused of being sexually provocative with a young female patient and was fired. Our work then was to repair the damage done to her

self-confidence and her trust of others, and , sadly, to help her develop a less idealistic vision of the world. Fortunately, she will be attending Smith College for graduate work, situated in the "lesbian capital of the world."

### **Case Example:**

Irene saw me briefly for counseling during the summer break between her freshman and sophomore years at a large Ivy League university. Her problem was ironic: in her first year away, she had confirmed for herself the lesbian identity she had felt emerging in her high school years. There was tremendous support for her identity development at the college she attended. Moreover, her parents, who had raised Irene in a bohemian neighborhood of a large city, were entirely accepting of alternative lifestyles. In fact, her mother had told her years earlier that she suspected Irene might be gay and that, if this were true, the mother would do all she could to help her. But Irene found herself unable to "come out" to her parents, and this filled her with self-recrimination. Therapy helped her to understand that her reluctance to "come out" had little to do with internalized homophobia and lots to do with needing a way to separate from her liberal but overprotective parents.

### **Bisexuality, Nonmonogamy, Sado-Masochism and Sexual Fringe Issues**

In the last decade sexual minority issues even more taboo than homosexuality have come bursting out of the closet. It is worth mentioning a few representative cases because sex therapists are more likely than other practitioners to encounter clients who occupy relatively unpopulated positions on the sexual landscape. In many of these situations the presenting problems have nothing to do with the unusual sex behavior. On the contrary, just as twenty years ago many gay clients sought out gay-affirmative therapists so that they *wouldn't* have to talk about their sexual orientation, so today other sexual minorities may seek out sex therapists, especially those known to work with the gay community, in order to find a professional who will not be shocked or repulsed by their lifestyle. When working with these clients, it is important that the therapist put aside preconceived concepts of "normal" and "pathological" sexuality. At IPG our rules for "pathology" are simple. We ask ourselves, "Is it consensual?" and "Is anyone clearly being damaged here?" If the answers to these questions are "yes" and "no" respectively, we consider the sexual practices nonpathological.

### **Case Example:**

Michael and Jenny are a suburban professional couple that at first glance appear conservative, even a little bland. She is an internist and he is an executive in the finance industry; together they are raising two little girls. They were referred to IPG for marriage counseling by friends in the S/M community.

For the most part, Jenny and Mike needed help with problems common to many committed, long-term partnerships, with some notable exceptions. The couple was part of the polyamory subculture, a movement comparable to the experiments with "open relationship" in the 1970's. The polyamory community has emerged in large part on the Internet, through bulletin boards and newsgroups. Polyamorists who meet and correspond with each other "on line" may eventually extend this to meeting "in the flesh."

Polyamorists have a vision of establishing extended families and small communities in which multiple committed romantic and sexual partnerships are the norm. For

example, Mike and Jenny have a third man, Jim, who lives with them, serves as an "uncle" to their children, is a sexual partner of Jenny, and who is Mike's best friend. All three are involved as family members and sexual partners of another polamorous trio in a nearby state. Jim and Mike have outside sexual partners as well.

When Mike and Jenny first entered couple counseling, Jim was their only "extra" partner. Mike had complaints about sex with Jenny, who was at that time his only sexual partner. His predominant sexual "script" involved physical beatings, with him as either giver or recipient of pain. Jenny's sexual tastes were more traditional, and it was nearly impossible for her to comply with Mike's wishes. What made treatment difficult was that even though Mike greatly desired to actualize his primary script, he was capable of becoming erotically aroused by virtually any sexual activity, and for a long time he refused to believe that he was unique. Therefore, he personalized Jenny's difficulties as covert attempts to control and punish him.

One therapeutic intervention was to have Mike "interview" his friends in the polyamory community until he realized that most of them had sexual repertoires far more limited than his. Once he accepted that he might never have the sexual relationship with Jenny that he desired, and mourned the loss of this fantasy, he turned his energy to active pursuit of partners who could participate in his scripts. He was successful. More recently, Mike has become close with a bisexual man. Mike very much wants to have sex with this man, primarily because he feels it would enhance the relationship. Although Mike is at most only incidentally attracted to men, he feels he can develop the ability to enjoy male-male sex because his sexuality is so flexible. Treatment interventions have included bibliotherapy and helping Mike identify ways he might find a "tutor" in the gay male community.

### **Case Example:**

Another atypical couple was Daniel, mentioned earlier as the bisexual man with gender issues, and his bisexual wife Kate. Both self-identified as bisexual

from adolescence. For the first ten years of their marriage they were monogamous. However, they practiced monogamy not because they held it as a moral value but simply because they felt their relationship needed a lot of stability before they could "open" the relationship without damage. Daniel is probably a "Kinsey 4 or 5:" more gay than straight. However, he is deeply in love with Kate and feels no conflict about giving up the possibility of a primary relationship with a man. Kate is most likely a Kinsey 2 – mostly straight.

Soon past the ten year mark in their marriage, Kate and Daniel came to IPG for help negotiating the change in the relationship. At IPG, our experience with couple counseling for gay men gave us substantial expertise with the phenomenon of non-exclusive relationships. With our help, Daniel and Kate 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. Daniel, Kate, and Luis met for sex and friendly companionship several times and the couple negotiated feelings of jealousy, exclusion, and insecurity that arose very well. However, Kate was unhappy because she wanted same-sex contact herself. They located other couples who desired this kind of sexual contact by, once again, accessing the Internet, which is a golden resource for those on the sexual fringe. Here, however, they discovered that most "bisexual couples" were in fact heterosexual men with bisexual women, and Daniel became frustrated. After a year

or so or 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 good friends as well.

### **Desire Discrepancy and Other Sexual Script Issues**

As noted earlier, the most common sexual problem that lesbians bring to treatment is desire discrepancy/inhibited sexual desire. Treatment is complicated by a number of factors. One factor that stands out as characteristic of lesbian couples is that the woman who desires sex more is usually not contented with being pleased by her mate. She often insists that her partner be "turned on" and even have orgasm. In part this is because women have a hard time being selfish about sex. A lesbian might have a very hard time enjoying receiving pleasure without reciprocating, because she believes this is morally wrong. This makes one potential solution to discrepant desire – that the less sexual partner give but not receive pleasure at times – more difficult for the therapist to negotiate.

Compared to men, women sometimes seem to have dramatically sharp drops in sexual desire after the limerance period of a relationship wears off. When this happens to only one woman in a lesbian couple, her more desirous partner tends to feel rejected, not only because she equates decreased desire with decreased love, but also because she believes "love conquers all." In other words, if the less sexual partner "really wanted to," she could feel more desire. The less sexual partner, on the other hand, may believe that high sexual desire is "objectifying" and a bit crude, and feel her lover's interest in sex is inappropriate.

### **Case Example:**

Reggie is a lesbian in her mid-thirties with a strong sex drive. She and Betty had great sex for the first six months of their relationship. As is all too typical of lesbian couples, they moved in together and pledged undying love after three months. By the time Betty's interest in sex had dropped precipitously Reggie had made plans to accompany Betty to China to bring home the daughter Betty was adopting as a single mother.

After nine months together the difference in sexual desire between the two women was vast; Betty probably would have been content with sex four times per year and Reggie would have liked four times per week. Had their lives been less entangled they might have parted when this became clear. Instead, with so much at stake, the couple entered sex therapy. Reggie took Betty's lack of interest very personally, and in turn Betty couldn't understand how sex could be so important to Reggie that she might leave a relationship because of it. In the midst of couple counseling with a lesbian therapist who seemed to subtly reinforce Betty's position, Reggie came to IPG for help. We validated her need to have sex play a strong role in her relationships, essentially helping her overcome her guilt at leaving a "marriage" entered into far too hastily.

The case of Reggie and Betty highlights another issue new to the gay and lesbian community: how to handle separations where children are involved. In this case, Betty had initiated adoption as a single parent long before meeting Reggie, and neither woman assumed that Reggie would be an equal co-parent. In fact, since the separation Reggie has attempted to stay involved with Molly, the little girl Betty adopted, with Betty's blessing. But when two women or two men have a child together the picture is complicated and difficult. In most states, same-sex partners

have neither rights nor responsibilities as co-parents. They are neither expected to pay child support after separation – nor are their rights to visitation recognized. An angry and vengeful parent can often terminate the relationship the ex-lover has with their child with complete legality. Fortunately, Betty and Reggie have engineered an amicable separation and Betty has her daughter's best interests at heart.

#### **Case Example:**

The case of Walter and Bob, by contrast, is an example of a better working out of discrepant desire. The difference in sex drive between Walter and Bob was probably about the same as that for Reggie and Betty. But other aspects of their situation were dissimilar. Neither man believed the other was "wrong:" each accepted the situation for what it was – a difference between them with no personal meaning. The discrepancy, however, had been apparent from the beginning of their relationship. Bob never showed high sexual desire, even at the height of romance. Walter, however, was pragmatic. He had had plenty of lovers in the past who were great in bed and made terrible partners, so he appreciated Bob's maturity and capacity for non-sexual intimacy. Compared to Reggie, Walter did not romanticize sex at all, nor did he believe Bob capable of extraordinary change. Further, Walter was older and had had extensive sexual experience. He did not experience the lack of earth-shattering sex in his relationship with Bob as a sadness or deprivation. Finally, both men were able to work out some compromises in which Bob "helped" Walter masturbate to orgasm when he himself was not "in the mood."

#### **Case Example:**

Aurora and Shelley's sexual problems are somewhat typical of the queer community. These women began sex therapy because Shelley seemed to have lost nearly all her interest in sex with Aurora. 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 acted upon her desires up until this point. Because s/m sexual activity is so public and, by now, so generally accepted within the lesbian community, Shelley knew she could easily get support for her interests and opportunity to actualize her fantasies. Aurora, on the other hand, was an incest survivor who was horrified at the thought of sex that involved dominance and submission. Ultimately, the women separated, and Shelley became active in what is sometimes called the "leatherdyke" community.

#### **Sex Addiction in the Millenium**

Although the concept of sex addiction is fraught with opportunity for moralistic and sex-negative abuse, sometimes one works with individuals for whom no other model seems appropriate.

#### **Case Example:**

Billy came for help when he felt he was destroying his relationship with Roger and endangering his own health. Before the HIV epidemic, Billy had had a "golden showers" fetish. His sex life had revolved around public scenes in the backrooms of gay bars in which scores of men urinated upon him. Because this sexual activity actually carried little risk of HIV transmission, Billy had never become infected, but the AIDS epidemic resulted in the closing down of the backroom settings where Billy's sexuality had played out. Forced to change his sexual script, he began to have sex in public parks and bathrooms, acting as a "bottom" in oral sex, i.e., the person

who gives oral sex and might swallow semen.

Billy became involved with Roger in 1989 and for a while he gave up public sex. But when Roger and Billy became more intimate and eventually lived together in a marriage-like arrangement, Billy found he lost interest in sex with Roger. He discovered that his desire was fully dependent upon an element of risk, danger, and anonymity. He was no longer capable of play-acting dangerous sexual scenes with Roger as the two had done early in the relationship. "I can't have that kind of sex with my 'wife,'" he complained, sounding eerily like a heterosexual man. "And I'm not interested in sweet, close sex."

Billy eventually joined Sex Addicts Anonymous in desperation. For several years he was completely asexual, as even masturbation aroused almost uncontrollable urges in him to "act out." Fortunately, his partner Roger was able to take "the long view." Roger had himself had a great deal of sex in the pre-AIDS era and was willing to sacrifice partner sex for an otherwise extraordinarily loving and intimate relationship. Even years later, Billy could only occasionally be sexual with Roger.

### **Case Example:**

Byron was addicted to the World Wide Web, but in his case his "addiction" may have been a step forward. When Byron entered treatment he was an anachronism. Well into his fifties, Byron had "come out" in the bad old days of complete shame and secrecy, and his history included flight into the priesthood to escape his sexual urges, disillusionment with the priesthood when he discovered the extent of homosexual activity within the monastery walls, and suicide attempts and hospitalizations.

Byron had never had a steady lover and rarely had sex; he was isolated and self-hating. Then he discovered the Internet. Byron invented a persona for himself of a twenty-something "hunk." He scanned a picture of a young man taken from a pornographic magazine into his computer profile, and corresponded with dozens of admiring cybersuitors. He became cybersexually active and his mood brightened considerably. He had some anxious moments when his suitors pressed to meet him in "3-D," or real life, but always managed to elude this attempts at face-to-face meetings. Despite the obvious fact that his suitors were falling in love with a fictitious Byron, Byron seemed to derive satisfaction and self-esteem from these interactions. It was as though he was experiencing an adolescence he had never had a chance to explore. Byron's addiction seemed benign, and when he left treatment he had no desire to expand his sexual relationships to the flesh.

### **CONCLUSION**

Although work within the queer community challenges the therapist to learn things not usually taught in graduate school, the clinician benefits from this work perhaps more than the client. For example, after several years of working with members of the S/M, or "leather" community, I noticed that S/M partners often had unusually good communication with each other about their sexual likes and dislikes, and I began to teach my non-S/M clients communication skills I learned from the "leather" population.

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. You may want to use the IPG 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.

Counselors must also stay current with developments in the "queer" community. A subscription to a gay magazine, trips to a local gay bookstore, or periodic searches at websites like, for example, amazon.com , are helpful, as continuing education courses about the sexual fringe are difficult to find.

The therapist who works with the queer community must not be afraid to admit not knowing. It is often useful to ask clients themselves for information; they feel flattered and more empowered in their own treatment.

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 minority clients; nevertheless, most therapeutic interventions will not vary that much from interventions used in a more mainstream population.

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