

## Low Sexual Desire in Lesbian Couples

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*Margaret Nichols raises several basic and provocative questions about the nature of female sexuality in her chapter on sexual desire disorders in gay women. She notes that lesbian women report the lowest level of sexual exchange of any pair-bonded relationship, and wonders whether this is a commentary on some quintessential feature of female sexuality. Specifically, she proposes that in the absence of male initiation and orchestration, women are socialized to engage in sexual exchange infrequently, and then only in the context of an intimate relationship. Furthermore, in the case of gay women, the very intimacy that seemingly provides the justification for sexual desire discourages it because of the overly enmeshed nature of lesbian relationships. Nichols suggests that this tendency to fuse with a partner so that differences are ignored, discouraged, or denied prevents sexual desire from being experienced. For it is possible, as Tripp (1975) suggests, that desire is dependent upon "barriers" or "differences" between people that are overcome through sexual connection. As Nichols notes, "one can only desire to have sex with another person when that person in fact exists as a distinct, separate entity." Part of the therapeutic task, then, is to help partners in a lesbian relationship to become emotionally autonomous and comfortable with tolerating distance and difference from each other.*

*Nichols suggests that several other factors may be significant in understanding the dynamics of low desire in gay women. The sexual acculturation of women as a group encourages them to feel greater sexual conflict than men, apart from any biological differences in sexuality (which Nichols believes do not constitute a critical factor accounting for women's lower levels of sexual interest). Furthermore, women are much more likely than men to have experienced sexual abuse. In a lesbian couple, the probability is twice as high that both partners will have sexual conflicts and/or a past*

history of coercive sexual contact. Consequently, lesbian partners are less likely to initiate sex in the first place, and more ready to adapt comfortably to a relationship without sex. In addition, feelings of sexual guilt and repression limit each partner's repertoire, so that the sexual script is constricted in terms of the motives for undertaking physical exchange, as well as in the nature of the exchange itself. Nichols indicates that the extent of proscribed activities in gay couples is often considerable, ranging from any hint of polarized roles (i.e., dominant-submissive, passive-active) to any sexual activity that appears "male-identified," such as sex involving penetration. The narrower the acceptable sexual repertoire, the greater the likelihood of future sexual boredom and sexual apathy.

Finally, Nichols wonders whether some instances of inhibited desire in gay women stem from repression, blocking noxious and unacceptable sexual impulses or fantasies. Clinically, it sometimes appears that beneath the sexual repression, libido is strong and forceful, and even frightening to some female clients. Such women deal with anxiety about losing control by clamping down on any sexual interest whatsoever.

These and other issues are explored in this fascinating and well-conceived chapter. The questions raised about female sexuality are provocative and deserve consideration, and the case vignettes provide powerful illustrations of the points Nichols makes.

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It is fitting that this book should contain a chapter on desire disorders in lesbian couples, as evidence suggests both that lesbian couples are the least sexually active of all types of couples, and that lack of desire is the most common complaint of lesbian couples seeking help for sexual difficulties. The data on normative sexual practices of lesbian couples are informative. Sociologists Blumstein and Schwartz (1983), using a large and carefully selected sample, compared heterosexual married, heterosexual unmarried, gay male, and lesbian couples along a number of dimensions, including sexuality. They found that lesbian couples had sex far less frequently than any other type of couple studied. Only about one-third of lesbians in relationships of 2 years or more had sex once a week or more. Of lesbians in long-term relationships, 47% had sex once a month or less. This is in striking contrast, for example, to heterosexual married couples: Two-thirds

of these couples had sex once a week or more, and only 15% of long-term married couples had sex once a month or less. Although no comparable study of different types of couples seeking sex therapy exists, clinicians writing about lesbian sexuality (e.g., Loulan, 1984; Nichols, 1982, in press; Todor, 1978) have remarked on the high prevalence of desire disorders, and reports of therapy with lesbian couples frequently mention low sexual frequency as part of the symptomatology of disturbed relations (Burch, 1982; Decker, 1984; Kaufman, Harrison, & Hyde, 1984; Roth, 1984).

Before discussing diagnostic and therapeutic issues, let us consider the meaning of these observations. It is important to reach some understanding about these facts, not only so that we may provide better treatment for lesbian couples, but also so that we may better understand sexual desire—for that matter, sexuality—in all women, not only lesbian women. For the case can be made that the study of lesbian couples allows us to make inferences about how women behave without the mitigating force of men in relationships, just as the study of gay male relationships gives us valuable information about how men behave together without the countervailing influence of women.

As will be argued later in more detail in the section on etiology, the sexual problems of lesbian couples seem to have more to do with the dynamics of female sexuality and the effects of female–female pairings than with dynamics of homosexuality. The clearest evidence for this comes again, from Blumstein and Schwartz's data on gay male couples. Gay men had somewhat less sex in their primary relationships than did heterosexual couples; on the other hand, gay males had the highest rates of extrarelationship sex. This means that lesbians in couple relationships are less sexual both within and outside the relationship than anyone else, just as other studies have found that uncoupled lesbians have less frequent sex and fewer partners than do gay men (Bell & Weinberg, 1978; Jay & Young, 1979).

If this is true—namely, that the low sexual frequency and high incidence of desire problems among lesbian couples has more to do with lesbians' status as women than with their status as gay people—then what questions are raised by those data about female sexuality in general?

First, the data confirm all other studies, from Kinsey, Pomeroy, Martin, and Gebhard (1953) to Hunt (1974), that show women to be less sexually active than men. This suggests not only that contemporary female sexuality is different from contemporary male sexuality, but that the pressure to be sexually active in heterosexual pairings seems to come from male partners more than from female partners. Indeed, at least one prominent researcher suggests that even among those who define themselves as suffering from problems of low sexual desire, men and women differ markedly, with men reporting situational or secondary desire disorders and women reporting primary problems; half of women report *never* experiencing sexual desire (Schreiner-Engel, 1986). Moreover, Blumstein and Schwartz's findings indi-

cate other differences as well. Their lesbian subjects preferred hugging, cuddling, and other nongenital physical contact to genital sex, reminiscent of reports from heterosexual women in such surveys as *The Hite Report* (Hite, 1976). Similarly, lesbians in the Blumstein and Schwartz (1983) study, like those studied by Jay and Young (1979), seemed more constricted in their range of sexual techniques than other couples. For example, 61% of lesbian couples had oral sex "infrequently or not at all," leaving the repertoire of the majority of couples limited to manual stimulation and tribadism. Lesbians had about the same rates of nonmonogamy as did heterosexuals (28% reported at least one extrarelationship episode), although they had far less "outside" sex than gay men, for whom nonmonogamy was the norm rather than the exception. But lesbians, like heterosexual women and unlike both gay and straight men, were likely to have "affairs" rather than just sexual encounters. The conclusions one draws from these data are that lesbians as a group exhibit comparatively low rates of sexual activity, constricted sexual repertoires, and a nongenital orientation, and they appear to link sexuality, including extrarelationship sex, with romance. In other words, they exhibit stereotypic female sexual behavior.

If female sexuality is different from male sexuality, with lesbians showing a "pure" form of this behavior, how and why is it different? This question is a central issue for sexologists. As I attempt to demonstrate in the next section, one's theoretical position on this issue is an important determinant of the treatment methods one employs for lesbian women; in fact, it has implications for treatment of sexual desire problems for all women.

Let us again consider this issue from the perspective of lesbian sexuality. While it is exceedingly difficult to obtain accurate historical data, some researchers have attempted to describe lesbian behavior and relationships in America over the last century and a half (Bullough & Bullough, 1977; Faderman, 1981, 1983; Roberts, 1977, 1982). Faderman (1981) has directly addressed the question of the role of genital sexuality in lesbian relationships. She has described the widespread existence of "romantic friendships," lifelong romantic relationships between women in the 19th and early 20th centuries that resembled heterosexual marriage but probably involved little or no genital sexuality. Faderman argues for a definition of lesbianism that stresses pair bonding and nongenital affection rather than genital sex; she continues this argument in *Scotch Verdict* (1983), her book about the famous legal case that formed the basis for Lillian Hellman's *The Children's Hour*. Other research on this topic is more tentative. Bullough and Bullough (1977) report moralistic, antisex attitudes among a group of lesbians who lived in the 1930s in Salt Lake City. Jonathan Katz and the San Francisco Lesbian and Gay Historical Society (Katz, 1976) have documented the phenomenon of "passing women"—women who successfully masqueraded as men for their entire lives at about the turn of the century. They report that some of these individuals married and were not known



to be women even by their wives! Again, this suggests an absence of genital sexuality in these relationships. Certainly not all lesbian relationships in this or previous time periods have been devoid of genital passion. Nevertheless, on the basis of admittedly scanty evidence, it is possible to hypothesize that genital sexuality may play a less important role in lesbian relationships than other pairings, and that this may have been true, at least in Western culture, for the last century and a half. During this historical time period, lesbian sexuality may well have mirrored an extreme version of heterosexual female sexuality (Shade, 1979).

### Lesbianism and Female Sexual Identity

If we accept lesbian sexuality as a prototype for all female sexuality, we conclude that women exhibit less interest in genital sex than do men; that female sexuality is more connected to love or at least limerance (i.e., the passionate intensity of a new romantic relationship); that female sexual repertoires are narrower; and that women care more for the nongenital, physical contact aspects of sex than for genital sexual expression. Why might this be so? Arguing one's position on this issue has implications for treatment. While it is beyond the scope of this chapter to examine this question in depth, it is interesting at least to consider the various subissues raised by this question, which have divided not only sexologists but also feminist theorists.<sup>1</sup>

The most obvious question to be asked about these differences is whether they are somehow "intrinsically" gender-related. That is, do lesbians exhibit this particular form of sexuality because women are somehow "wired" differently from men and, in the absence of male influence, display their "true natures"? A number of investigators of gay and lesbian sexuality, most notably Tripp (1975), have argued for this proposition; many feminists, particularly those involved in the antipornography movement, would agree. According to this viewpoint, male sexuality is *genetically* and *hormonally* different from female sexuality, being more polygamous, more active, more aggressive, less tied to love, and more genital-orgasm-focused, while female sexuality is *genetically* and *hormonally* determined to be more monogamous, less active, more tender and gentle, more tied to love, and more sensual than genital and orgasmic. Moreover, some of those who

1. One of the current controversies raging within the women's movement centers around feminist interpretations of female sexuality. Readers desiring to pursue this controversy are referred particularly to two books—*Powers of Desire* (Switow, Stansell, & Thompson, 1983) and *Pleasures and Danger* (Vance, 1984)—and to Vol. 10, No. 1 of the journal *Signs*, which contains a forum entitled "The Feminist Sexuality Debate."

argue that these fundamental differences exist—notably feminists in the antipornography movement—would also maintain that our culture in general and the sexology field specifically is dominated by a male-centered point of view.

If one subscribes to this perspective, one might question the very notion of “low sex drive” as being problematic, and indeed might point to the existence of problems created by high sex drive (e.g., promiscuity or sexual compulsivity). A clinician with this belief might counsel a lesbian couple whose sexual frequency is low that their only “problem” is in viewing low frequency as a problem, much as most sexologists these days would counsel a client who complains that his or her urges to masturbate are problematic. In fact, there are undoubtedly many lesbian couples, possibly more than other types of couples, who exist happily for years with little or no genital contact in their relationships. This phenomenon, of course, calls into question many of our most cherished beliefs about relationships. Many of us believe that sex is part of the “glue” that binds couples together, and some of us would not define two people who do not have genital sex together as “lovers.” Nevertheless, many lesbian couples continue to define themselves as “lovers” despite an absence of genital contact, and clinicians would do well to keep this in mind when counseling lesbians. For example, in an initial interview with a lesbian couple, one could probe for the *reasons* why low sexual frequency is perceived as a problem: Are one or both partners genuinely disturbed by the low frequency, or do they merely feel that they “should be” having more sex? One might also frame an issue of low frequency or desire as a *discrepancy* between the desires of the two partners, rather than a “problem” for the one with low desire.

However, while it may be true that many women experience sex as a relatively unimportant or even onerous part of their lives, and while it is also possible that lesbian couples may not always want or need frequent genital contact in order to be satisfied with their relationships, it does not necessarily follow that women and men are somehow “intrinsically” different regarding sexuality. The feminist/social-constructionist perspective holds that sexuality has historically always been a “danger zone” for women. Carole Vance (1984) summarizes this position beautifully:

Women—socialized by mothers to keep their dresses down, their pants up, and their bodies away from strangers—come to experience their own sexual impulses as dangerous. . . . Self-control and watchfulness become major and necessary female virtues. As a result, female desire is suspect from its first tingle, questionable until proven safe, and frequently too expensive when evaluated within the larger cultural framework which poses the question: is it really worth it? When unwanted pregnancy, street harassment, stigma, unemployment, queer-bashing, rape and arrest are arrayed on the side of caution and inaction, passion often doesn't have a chance. (pp. 232–241)

Thus the story of female sexuality can be seen as primarily a story of unrealized, blighted, or thwarted potential. This chapter is written from that perspective. Interestingly, part of the "evidence" for the view comes again from the lesbian community. In the last decade, there has emerged a lesbian "sex radical" movement that stands in polar opposition to the problem of low desire in lesbian couples. Lesbian sex radicals are producing erotica, forming "sex clubs," engaging in "kinky" sex, and otherwise exhibiting what could be viewed as stereotypically "male" behavior, but often with some particularly female influences. The sex radicals suggest that, at least for some women, low sexual desire is not at all normative. Indeed, in my mind the more interesting questions about female sexuality involve *how* it has been, shall we say, contained and limited in relation to male sexuality. Are we dealing with a process of repression, for example, or is it more relevant to think in terms of undeveloped or underdeveloped sexual interest? Do women have a lower "sex drive" than do men, or is it more productive, say, to imagine that men have learned to use sex to serve a variety of functions (intimate, ego-reinforcing, recreational, etc.), while women have learned only to use sex to achieve intimacy? Is it at all relevant to speak of "sex drive" as a *quantity* within an individual, or are we rather describing an end result of an interaction process between (usually) two human beings?

These questions force us to examine the most basic ways in which we conceptualize sexuality. Do we think of sex as a "drive"—that is, some kind of primary energy force that cannot be expressed, repressed, or converted, but that is somehow hydraulically fixed in quantity? Or do we think rather of sets of behaviors that vary in frequency, type of outlet, and functions served, and that may be conditioned or otherwise environmentally encouraged or discouraged, but that are in no way fixed or predetermined in the individual? Throughout this chapter "sexuality" is referred to in both ways: both as an energy that first exists and can be repressed, and presumably somehow is still "present" despite repression; and simply as a "potential" to be developed or undeveloped as circumstances dictate or as the result of interactive processes.

### Patterns of Low Sexual Desire in Lesbian Couples

It is important to note that there is no evidence that lesbians are less sexually responsive than heterosexual women in general. In fact, some data suggest that, overall, lesbians may be more sexually responsive and more satisfied with the sex they do have than heterosexual women are (Masters & Johnson, 1979). Indeed, Masters and Johnson (1979) hypothesize that the sexual techniques of lesbians are generally more suited to the sexual needs of women than is heterosexual sexual activity. It is significant that lesbians do

not have pervasive, across-the-board sexual problems. Rather, their problems seem confined to one specific type: sexual desire/frequency *within committed relationships*.

Barbara and Sharon were a typical couple I saw for therapy. Lovers for 8½ years, they had had little or no sex for the last 3 years of their relationship. At the onset of therapy, they had lived apart for over a year in an attempt to reassess the relationship; they were now considering living together again, but were concerned about the lack of genital sexuality. Both reported an initially high rate (two to four times per week) of sexual encounters during their courtship, but a gradual decline in activity over the years. Both agreed that Sharon was the less sexually interested of the two, but that after a prolonged period of being rebuffed, Barbara had "given up" approaching Sharon for sex and had herself lost desire. Nevertheless, the couple agreed that the sexual encounters themselves, although infrequent, had always been satisfactory. It was as though it just became inordinately difficult to "get started" with sex. Both women reported fairly typical histories of masturbation and arousal; in other words, neither exhibited a primary desire disorder. Moreover, both were aware of sexual attractions to other women. Finally (this may seem unusual to the outside observer, but it is highly typical for lesbian couples), both women had come to accept this situation. They clearly did not feel the need for genital sex in order to define themselves as "lovers." While they were sufficiently concerned to seek therapy, neither was willing to make sex the cause of ending their relationship. This attitude, so typical for lesbian couples exhibiting desire disorders, is particularly interesting because lesbian pairings are relationships held together by no social glue—neither legal marriage bonds, children, financial dependency, social acceptability, nor any of the other types of pressures that may hold together a heterosexual marriage even when marital satisfaction is flagging. Lesbians, by and large, have no reason to stay together other than personal/emotional reasons, yet even under these circumstances women rarely see lack of genital sexuality as an important enough reason to separate.

This phenomenon again raises the issue of how to define what is and is not a sexual problem. If lesbians do not seem overly disturbed by a lack of genital sexuality, why should sex therapists be concerned? Why did I not simply tell Barbara and Sharon that their worries over the lack of genital sex in their relationship were simply the result of their being inculcated with patriarchal, male-oriented standards of sex? They displayed ample evidence of nonsexual physical affection and companionship. Why did I not reassure them and send them home? This approach would indeed, have been a legitimate alternate approach to the one that was adopted, and one that might have worked as well. Nevertheless, a therapy contract was established to help Barbara and Sharon reintegrate genital sexuality into their relationship, for several reasons. First, breakup in lesbian couples often does seem



to be associated with low genital sexual activity within the couple (Blumstein & Schwartz, 1983). Although partners may not complain overtly of the lack of sex, one partner often begins an outside affair after a period of sexual abstinence, falls in love with the new partner with whom she is having sexual contact, and ends the first relationship. In other words, although lesbian couples may not consciously experience the lack of sexuality within their relationship as an acute problem, it does seem related to relationship breakup. One could easily argue that this correlation is not causal—that this simply demonstrates a particular pattern by which lesbians end their relationships. While this may be true, it appears that sex is part of the glue that binds many lovers and spouses. Therefore, although couples who maintain that they do not need genital sex should not be directly challenged, when couples complain of lack of sex, one can reinforce the idea that sexual intimacy will enhance the relationship. Indeed, I often find myself in the position of attempting to increase the level of conflict about sex in lesbian relationships, or at least to reinforce the idea that it is permissible to want sex and to be dissatisfied with none! Frequently, lesbians have such a strong consciousness about the degree of sexual harassment that women experience in the culture at large that they are reluctant to pressure their partners at all for sex, lest they appear too "male-identified."

In summary, then, the characteristic patterns of low sexual desire exhibited by lesbians are as follows: (1) secondary rather than primary desire difficulties—that is, women experience low desire only within the context of ongoing, committed relationships (although it is typical for a given woman to have experienced low desire in all her relationships); (2) general satisfaction with sex when it does occur; (3) relatively low rates of argument or conflict about sex within the relationship; (4) often, harmonious or apparently harmonious interactions in nonsexual areas of the relationship. Indeed, these relationships sometimes appear stable and conflict-free; often partners report little or no overt hostility about anything in the relationship. In many cases, it appears that the low-desire problem is part of the more general manner in which the couple handles conflict: through avoidance, smoothing over, and denial.

### *Causes of Low Sexual Desire in Lesbian Couples*

It is easier to specify the things that do not cause low sexual desire in lesbian couples than to explain why it exists. It is certainly not because of distance or lack of intimacy, a common cause of sexual dysfunction in other types of couples. A substantial body of literature exists to document that lesbian couples, if anything, may suffer from too much closeness in their relationships (Burch, 1982; Decker, 1984; Kaufman *et al.*, 1984; Roth, 1984).

Strategies designed to encourage partner intimacy will probably not be necessary for this population.

Low sexual desire is also infrequently caused by power imbalance or sexist roles and concomitant oppression of the "feminine" partner in lesbian partnerships. Again, a substantial body of literature exists to suggest that lesbian couples are idealistically and to some extent pragmatically more egalitarian than other types of couples, especially heterosexual couples (Caldwell & Peplau, 1984; Cochran, Rook, & Padesky, 1978; Maracek, Finn, & Cardell, 1982). And although the phenomenon of "butch-femme" roles was characteristic of lesbian couples of the 1950s and 1960s and is re-emerging in the 1980s as a sexual dynamic, these roles really resemble male-female roles rather superficially (i.e., in terms of physical appearance and dress) and are fairly irrelevant to the population of lesbians generally discussed in this chapter (Nestle, 1984; Nichols & Leiblum, 1986).

Moreover, low sexual desire in lesbians is probably not primarily due to internalized homophobia. Gay men, after all, have experienced as much societal oppression as have lesbians, and it has not seemed to dampen their sexual desire significantly. Berzon (1979), however, has suggested an interesting way in which internalized homophobia may interact with female socialization to suppress sexuality, and her theory has at least some face credibility. She posits that when gay adolescents attempt to reconcile their emerging sexual impulses with the expectations that they and others have that they will be heterosexual, males and females "manage" these impulses differently. According to Berzon, gay male adolescents tend to engage in sexual behaviors while avoiding personal intimacy, and by so doing rationalize that they are not "really" homosexuals. Gay female adolescents, on the other hand, express their impulses through close and intimate but nongenital relations with other women, thereby avoiding the lesbian self-label. Moreover, argues Berzon, this stylistic difference continues to be exhibited by gay men and women into adulthood even after a homosexual identity has been acknowledged.

If low sexual desire among lesbians is not caused by lack of intimacy within the relationship, unequal power within the relationship, or internalized homophobia, what then are its causes? Three dynamics may be relevant: (1) fusion/merging in the lesbian couple; (2) dynamics of guilt and repression; and (3) dynamics related to the particular way in which sexual desire is "fueled" in women. All three of these causes are tied, not to the fact that lesbians are gay, but to the fact that lesbians are women and to the nature of the interaction of women with women as opposed to women with men.

### Fusion

What is fusion, and how is it related to low sexual desire? Almost all authors commenting about lesbian couples have noted a tendency for

female-female pairings to be close and intimate, sometimes to pathological excess; this phenomenon has been labeled in family systems terms as "fusion" or "merging." It is interesting to speculate why this tendency seems more marked in female couples than in other types of pairings. In our culture, women are socialized to value closeness and "togetherness" and to strive for this in relationships, as opposed to the male socialization toward autonomy and away from closeness. One would expect, then, that males bring a pressure toward autonomy to relationships and women bring a pressure toward closeness. Indeed, fusion is rarely encountered as a problem in gay male couples and appears to be less frequent in heterosexual couples than in lesbian couples. In a sense, fusion represents the pathological extreme of what Gilligan (1982) portrays as the female orientation toward "connectedness": That is, it is the desire to relate so much to the connections between people that interpersonal boundaries, individuality, and separateness become obliterated.

Kaufman *et al.*, (1984) describe this type of relationship as it typically occurs in lesbian couples:

[This] relationship distress is characterized by excessive closeness between the women, extreme and intense ambivalence, and a failure to establish emotional, territorial, temporal, and cognitive space for each individual. . . . These lesbian couples . . . appeared to be too closely merged and symbiotic. . . . For these couples the initial merging that occurred with the early stage of falling and being in love would not yield to increasing pressures from the environment. The oneness, a kind of narcissistic failure to allow for separateness or a defense against difference had become the norm or the expected state they would strive to achieve and maintain through more and more closeness. . . . Each ignored her own needs for space as well as those of her partner. . . . (p. 530).

Kaufman *et al.* present a cluster of behaviors typical of such couples: (1) attempts to share all social and recreational activities, with contacts limited to only those that the couple does share; (2) no individual friends, only friends shared by the couple; (3) the sharing of professional services, such as doctors, dentists, or therapists; (4) often, the same employer, or, if not, regular telephone intrusions into the workday so that the partners rarely spend even a few hours without contact with each other; (5) little or no separate physical space or belongings, often extending to clothing and other personal possessions; and (6) communication patterns that indicate assumptions of shared thoughts, values, and ideals (e.g., sentences started by one may be completed by the other). As mentioned earlier, these couples represent an extreme version of the kind of closeness and intimacy in which all women are trained so well. In one sense, lesbians often achieve in their relationships what other women idealize. Or, as Kaufman *et al.* suggest: "We believe that these behaviors are strongly reinforced by cultural descriptions of the idealized romantic relationship of lovers, riding off into the

sunset, escaping worldly pressures and reality in their isolation, making promises of lifelong fidelity, and believing that they belong to one another" (1984, p. 531).

Lesbian couples make pulp romantic novels come true; in so doing, they may show us the "down side" of closeness—what the need and desire for intimacy can do when it is unmitigated by the more typically male behaviors aimed toward achieving distance and autonomy. For it is important to recognize that the closeness achieved in fused lesbian relationships is gained only through a sacrifice of individuality. Individual differences, dislikes, likes, and interests are suppressed in favor of the dyad; indeed, closeness comes to be defined as sameness. It is questionable, in fact, whether this type of closeness, paid for with the price of negating individuality, can even be defined as true intimacy. This need to suppress individuality, while comforting to some, often produces tension and ambivalence, which is expressed again in some characteristic ways. One way in which ambivalence can be expressed in these couples is through a pattern of fighting to achieve distance, at least temporarily. Another method is by suppressing sexual contact.

The relationship between fusion and suppression of sexuality is probably complex. On one level, avoidance of genital sexuality can be seen as a way to achieve distance in relationships severely in need of space, much as Kaufman *et al.* (1984) describe fighting in such couples as attempts to achieve at least temporary separation. On another level, one wonders whether genital sexuality is simply *unnecessary* in such couples. If we speculate that part of the desire for genital sex is the desire to have one's personal boundaries obliterated and to merge temporarily with another person, this desire is irrelevant in a relationship that is fused. In a sense, one can only desire to have sex with another person when that person in fact *exists* as a distinct, separate entity. In a merged relationship, only one entity exists, not two. Finally, these speculations raise questions about the nature of sexual desire and sexual attraction. Is desire, as Tripp (1975) believes, dependent upon "barriers" or "differences" between people that are overcome through the sex act? If this is true, then there are no differences to be temporarily bridged.

In therapy, it is important to diagnose the existence of fusion as a cause of low sexual desire, because the interventions one chooses to use in this case are quite specific. In another type of couple, one might often hypothesize that lack of sexual contact is the result of *too little* closeness; indeed, a great deal of marital therapy with heterosexual couples presumes a need for more or renewed closeness. This is rarely a problem for lesbians. Intervention strategies need to focus upon helping the partners achieve some separation and space from each other. The therapist may encourage the development of separate friendships or independent recreational activities, for example, or the expression of different viewpoints or values (even



conflict or arguing) in the relationship. Again, Kaufman *et al.* (1984) summarize the types of interventions that can be used with such couples as (1) promoting assertiveness and independence; and (2) helping the couple achieve separate space in areas such as physical territory, financial accountability, recreational activities, and cognitive and emotional life. The therapist must be prepared, however, to encounter several types of resistance. First, it is likely that the women in such a couple will equate individuality and independence with abandonment, and thus attempts to separate partners may arouse powerful feelings of jealousy, fear, and so on. Second, women in fused pairings are partly attracted to such pairings because they are looking for external validation of themselves through similarity (i.e., "If my partner and I *both* agree on a certain value or perspective, then I/we must be 'right'; if she disagrees with me, I *or* she must be 'wrong'"). Thus *difference* is seen as a threat to personal identity, not just couple relatedness.

This is very much a female issue. Typically, a woman is socialized to expect that her identity is incomplete until she has coupled with a man. A woman is expected, in fact, to retain a greater flexibility in goals, career, and the like than a man does, so that her life direction can remain open to the shaping that is given by her male partner. While lesbians reject having their lives defined by males, they often retain the belief that identity is defined by *the couple*. They frequently have no concept of identity as separate from a love relationship and may never have gone through a process of individuation that allows them to feel comfortable as separate individuals. While they have rejected the heterosexual woman's tendency to define self through husband and children, they may have substituted a tendency to define self through couplehood and/or affiliation with groups (e.g., a lesbian-feminist community). Thus, the clinician who begins dealing with a low-desire problem may, in attempting interventions to achieve distance, tap into deep individual issues—not only fear of abandonment, but fear of identity loss and failure to achieve real individuation.

This raises another issue related to fusion and therapeutic attempts to intervene with a fused couple. Partly because women tend to define self through couplehood, many lesbians have never really been "single" and tend to go directly from one relationship to another. This has two major consequences. One is that lesbians, like many other women, are often terrified to be alone and would rather stay in a bad relationship than be single. Second, it means that lesbians often tend to define their couple interactions as committed relationships after an inappropriately short period of "dating." It is quite common for a lesbian to move from the home of one lover directly to the home of a new lover. It is not at all unusual for lesbians to define themselves as being "in a relationship" after two or three dates. Operationally, this means that two women who are virtual strangers to each other are declaring themselves married for life. After such a declaration of commitment, it would be inconvenient, to say the least, for these

women to discover incompatibilities. Thus there is increased pressure to obliterate differences, because to acknowledge the existence of differences might lead to the discovery of incompatibilities that are real, concrete, and irresolvable. Thus the clinician attempting to uncover individual differences in a fused couple may indeed be precipitating the dissolution of the relationship through discovery of basic conflicts that, had the partners not become committed to each other so quickly, might have resulted in their never becoming "married" in the first place.

### Dynamics of Guilt and Repression

How are dynamics of guilt and repression related to low sexual desire in lesbian couples? There are three major ways in which such dynamics operate. The first and most obvious relates to the facts that women are culturally socialized to feel more conflict about sex than are men and that they experience more sexual abuse than do men. In a lesbian couple, there is twice as much likelihood that both members of the couple will have sexual conflicts. Thus, for example, if one could somehow measure positive influences toward sex and negative influences away from sex, a lesbian couple, as a unit, are likely to have fewer positives and more negatives. Among other things, this effect makes each member of the couple less likely to initiate sex in the first place, given the probability of a less than enthusiastic response from the partner. It also is partly responsible for the relative ease with which lesbian couples accept a sexless relationship: Even the more sexual partner in a lesbian relationship is likely to have some sex-negative attitudes, and her mate's conflicts complement her own doubts.

Second, guilt and repression tend to limit one's sexual repertoire. That is, sex-negative attitudes tend not only to be general ("Sex is bad") but also to be quite specific ("Fantasies are bad" or "\_\_\_\_\_fantasy is bad"). It is typical for lesbians to feel that the only kind of "acceptable" expression of sexuality is the spontaneous desire to have sex with a partner in a committed relationship, when sex is expressed through manual (and possibly oral) stimulation of equal duration for each partner in a loving, gentle, tender way, and both partners have orgasms (preferably at the same time and certainly of the same number and intensity). The list of "unacceptable" or "bad" sexual activities for lesbians may include the following: sex that is planned in advance; sex with any hint of polarized roles (i.e., dominant-submissive, butch-femme, active-passive); sex toys; fantasies about sex, especially fantasies about men; sex when only one partner has an orgasm; masturbation unless one is single; and sometimes sex that involves penetration (this may be seen as "male-identified"). Having a limited sexual repertoire may not be particularly important in the beginning of a relationship, when limerance fuels sexuality, but it probably becomes increasingly important later in the relationship, when variety can help to break routine.

The third way in which guilt and repression operate is the most difficult to describe, but is related to muted female sexuality. When some women who display low sexual desire engage in fairly intensive individual psychotherapy, they may eventually uncover sexual desires that are ego-dystonic. It appears in these cases that low sexual desire has been the result of a generalized sexual repression meant to block a particular noxious sexual impulse (e.g., sexual fantasies about men, sexual fantasies about the father for a father-daughter incest victim, sadomasochistic impulses). Alternatively, repression may serve to block a sexual force that in fact is quite strong and powerful; sometimes women with low sexual desire discover that beneath the apparent lack of libido is a powerful, varied, and sometimes quite terrifying sexual drive.

Notice that I use terms such as "underneath" and "drive," implying a hydraulic view of sexuality. It could be argued that the women I describe are "uncovering" nothing but rather are *developing* a sexuality where none has been developed before. This may be the case, but these terms have been chosen because often the intuitive sense one has in such cases is a feeling of repression of a powerful urge or impulse. A case example may serve to illustrate this point.

Miriam was a 28-year-old lesbian in a relationship for 2 years who complained of low sexual desire, inability to become aroused, and orgasm difficulties. Miriam came from an Orthodox Jewish background with severe antisex injunctions in her family. During nearly a year of treatment, Miriam repeatedly expressed two specific fears of sexuality. One was a fear that, during sex, she would urinate in bed; the other was that, if she allowed herself to become sexual, she would lose control and become promiscuous and therefore "bad." Eventually, I attempted a novel intervention: I suggested to Miriam and her partner that Miriam deliberately urinate in bed during sex. (The difficult part of this intervention was getting the partner to agree!) Perhaps not surprisingly, Miriam experienced this event as intensely pleasurable, and indeed reached orgasm during the episode. Subsequently, it was as if this event opened a literal Pandora's box of sexuality for Miriam. She became aware of a multitude of quite specific and strong desires that were also ego-dystonic: She felt attracted to large women, to women of different races, to strangers she saw on the subway, and so on. These desires frightened her, as she felt "flooded" by them, and in fact management of her desires did become an issue for her. She came quite close to having an extrarelationship affair, an event that was alarming to her.

Two things are interesting about this case: first, that Miriam's low desire seemed directly related to repression of an impulse that was experienced consciously as a fear (i.e., the fear of urinating); and, second, that Miriam's fear of loss of control of her sexual impulses had a grain of truth to it. In other words, once her sexual repression was lifted, Miriam indeed experienced her sexual desires as strong impulses that needed to be controlled. This is a phenomenological experiencing of sexuality that I think is

common for men but rather rare for women. One wonders what would happen if women really should succeed in lifting the weight that repression has placed upon their sexuality. Perhaps we might have to deal with some of the consequences of high sexual desire that men have more typically encountered, as well as concomitant problems such as paraphilias and sexual compulsivity.

### The "Fueling" of Sexual Behavior in Women

The final area of influence upon low sexual desire in lesbians relates to the one just discussed, and has to do with the way sexual desire is "fueled" or "driven" in women. Women, by and large, are socialized so that one thing and one thing only triggers sexual desire: limerance. Other things—simple physical attractiveness of a partner, a particular sexual act or technique, a desire to use sex for recreation or for tension release, and so on—either do not trigger desire or are not allowed to register as desire on a conscious level. This phenomenon is rather limiting. The limerance phase of a relationship always ends, and then, if limerance is the primary fuel for desire, the woman is left with these alternatives: becoming less sexual; trying to reactivate the limerance (to "bring back the romance" in a relationship, which is not always easy to accomplish); or becoming limerant with someone new. Many lesbian couples choose to become less sexual—and then eventually choose the third option, to become limerant with another partner.

An alternative to these choices is for women to redefine sexuality for themselves and to attempt to develop mechanisms other than limerance that trigger desire. This is, to some extent, happening in the lesbian community via the lesbian sex radical movement. Lesbian sex radicals are promoting a redefinition of sex for lesbians as, first and foremost, a tool for pleasure rather than as a tool for intimacy within a committed relationship. The sex radical movement, by producing written, auditory, and visual erotica, is attempting to broaden the base of women's desire to include fantasy, physical/visual stimuli, and more complex and sophisticated sexual techniques. In addition, these women are attacking many of the taboos women hold about sex in order to liberate sexual interest.

One final example, not clinical, may serve to illustrate many of the points discussed in this section. For the last year or so, I have conducted a series of sex workshops for lesbian and bisexual women. In these workshops, I show sexually explicit slides and tapes of erotica made by women for women, and incorporate experiential exercises designed to encourage women to express fantasies and desires and to share ideas about sexual techniques with each other. At first, I encountered great difficulty within these workshops. Lesbians were willing to share what they *disliked* about sex rather easily, and they invariably framed their dislikes in judgmental



terms often justified with political rhetoric: "The women in that film seemed hard and unfeeling, like men," "The sex was too unequal," "The women didn't really seem to care about each other." Finally, I had to make two rules about the workshops: Women were not allowed to talk about what they did *not* like, only what they did like; and feelings had to be expressed in personal "I" phrases instead of in general terms, and especially without political analysis. These rules entirely changed the tone and content of the workshops. Now women invariably express a broad range of quite varied sexual tastes. Most also say that they have never before been in an atmosphere where all their sexual tastes and interests will be accepted uncritically, and where sexual variety will be encouraged. Many say that they are, quite simply, starved for new ideas about sex.

### Therapeutic Interventions with Lesbian Couples Experiencing Low Sexual Desire or Frequency

When confronted with a lesbian couple complaining of low sexual frequency or low desire, one's first task, as in all therapy, is accurate and in-depth assessment. Typically, during assessment in these cases, one might attempt to answer the following questions:

1. Is this more the "problem" of one individual in the partnership, or is it more a relationship issue? In making this assessment, one should probe for, among other things, a history of sexual assault or incest in one or both partners.
2. Is this really a low-desire problem, or only a *discrepancy* problem (i.e., both partners experience desire to some significant extent, but there is a discrepancy between their ideal frequencies for sex)?
3. Is this problem the secondary result of another sexual problem (e.g., an aversion to oral sex—not uncommon among lesbians, and quite troublesome when it occurs)?
4. Is the frequency problem the result of simple boredom and need for sexual enhancement techniques?

Accurate assessment depends upon taking individual sex histories as well as a relationship history. The format of therapy must then be decided (e.g., couple sessions, individual therapy, or a combination of both). In making this decision, one must consider not only the perceived origins and maintenance of the problem, but also the willingness of both partners to cooperate in treatment. At times, conjoint counseling for problems that appear more individual is undertaken in order to use the "nonpathological" partner as a sort of sex surrogate for sensate focus or other exercises.

My approach in treatment tends at the outset to be cognitive-

behavioral and uses many of the standard interventions, such as education or sensate focus exercises; treatment becomes more psychodynamic when these approaches are unsuccessful. Because the overall approach is similar to that described in other chapters, it seems most useful to discuss aspects of treatment that are specific to this population or that may be unusual in my particular approach to treatment.

First, when working with lesbians, one always needs to be sensitive to issues of sexual assault or incest, because such occurrences are twice as likely to occur in a lesbian couple. Therefore, therapists working with this population need to be well versed in methods of ameliorating the damage done by sexual abuse. Second, it is important to realize that there does exist a lesbian community or subculture, and that this community, while diverse, is also distinctive in its values, traditions, and standards. In short, being a lesbian is comparable to being a member of an ethnic minority, and therapists should assess the extent to which their lesbian clients are immersed in this community. While this chapter does not permit an extended discussion of what therapy with lesbians entails, there are a few specific issues a therapist would do well to keep in mind:

1. The lesbian-feminist community considers sex to be a political issue for women (rightly, I believe), and all sexuality is subjected to political analysis. Unfortunately, some of this analysis amounts to a replacement of rigid traditional moralistic values by rigid feminist moralistic values. To the extent that clients "buy into" a lesbian-feminist ethic, the therapist may need to deal with cognitive values that support neurotic or unproductive behaviors.

2. If internalized homophobia is an issue, bibliotherapy may be in order. The therapist should consult the closest gay-lesbian or feminist bookstore and some of the hundreds of gay-affirmation publications available. Two indispensable books by and for lesbians specifically dealing with sexuality are Loulan's *Lesbian Sex* (1984) and Califia's *Sapphisty* (1980).

3. "Nonmonogamy" is still a political issue in some parts of the lesbian community. That is, lesbians rarely practice "adultery"; most extrarelationship sex is "above board" and open, and may be defended with political rhetoric. In any case, lesbians, like gay men, are much more likely than are heterosexuals to be experimenting with nontraditional forms of relationships, and clinicians need to keep an open mind about this.

4. Similarly, the lesbian sex radical movement has caused a substantial stir in the lesbian community, at least in urban areas on both coasts. In particular, issues such as pornography/erotica, sadomasochistic sex, and butch-femme roles—in fact, any form of sexuality in which roles are polarized—are controversial and may affect sex therapy. For example, I have had several cases in the last few years in which one partner of the couple wanted to join a lesbian sex radical group and/or experiment with "kinky" sex, and this became a therapeutic issue.

5. Finally, sex therapy with women often becomes more and more oriented toward uncovering deeper layers<sup>11</sup> of intrapsychic meaning in sexuality. To this end, I use a good deal of trance work, as illustrated in one of the cases described below.

### Three Cases: High, Medium, and Low Success

#### Melinda and Joyce: A High-Success Case

Melinda and Joyce were an ideal couple for therapy. Aged 48 and 53, respectively, they had been coupled for 23 years. Both women were well educated and articulate; both had prior histories of individual therapy, were well adjusted, and were knowledgeable about the therapeutic process. They reported that their reason for choosing to enter sex therapy at this time was that they felt that the rest of their relationship was in good order. In fact, they were correct.

At the time they entered treatment, they had had no genital sexual contact for over 1 year and little physical contact for 4 years before that. The first two sessions were spent on assessment. The partners were seen as a couple for the first session, and each was seen individually during the second session. After that, there were three treatment sessions and telephone follow-up over the next 6 months.

Melinda and Joyce's problem was conceptualized as a "script discrepancy" problem. Each woman had an internalized "script" of what she thought the sex act should be. Melinda considered orgasm to be the pinnacle of sexual expression; Joyce enjoyed arousal and all the hugging and cuddling surrounding sex. Joyce was quite willing to pleasure Melinda in any way desired, but she felt that for herself, orgasm was usually not worth the trouble it took to attain. Melinda felt that sex "wasn't sex" unless both women had orgasms; Joyce felt pressured to live up to Melinda's expectations. Over the years, sex had become an ordeal for both women, and it had become easier just to avoid it. During the second session, I probed for levels of sexual desire by asking each woman separately, "If you had sex exactly the way you wanted it, how often would you want it?" Interestingly, reported levels of desire in response to this question were not that discrepant: Joyce said that she would like sex about once a week; Melinda said that she would like it two or three times a week.

Therapy with this couple was brief and straightforward. During the third session, I explained to them that their problem appeared to be one of differing sexual scripts. I explained this concept and stated what I thought the differences were. Most of the session was spent in validating their different sexual performances—in particular, dealing with Melinda's anxiety, reinforced by her interpretation of lesbian-feminist ethics (i.e., that sex

where only one partner had orgasm was "unfair" or "oppressive"). She came to see that it was perhaps more "oppressive" to insist that her partner have orgasms. The couple was asked to attempt to do a sensate focus exercise.

This assignment went well, and sensate focus that included genital touching was assigned during the fourth session. At the fifth session, both women appeared, grinning sheepishly, to report that they had "disobeyed" my instructions and had had genital sex (for the first time in over a year). Shortly after this session, they left on a month-long vacation with plans to call me upon their return. They called to report that the vacation had gone well and that they had had several "successful" sexual encounters. Several months later they reported satisfactory sexual relations, which, while not as frequent as either woman would have wished, was a realistic outcome given their lifestyle.

This case was straightforward because the problem, while of long-standing duration, was a matter of misguided communication and values, with no real psychodynamic roots. However, the relative ease of solution depended upon Melinda's accepting Joyce's view that sex need not include orgasm. Some therapists might see Joyce's attitude as indication of an orgasm dysfunction (and perhaps it was), and would have attempted to help her attain orgasm more quickly or easily. I accepted her at face value, and it was upon this acceptance that my interventions rested.

#### Betty and Helen: A Case of Mixed Success

Betty and Helen had been lovers for 3 years, living together for 1 year, when first seen as clients. Betty made the initial therapy contact for individual treatment, but in her initial sessions she specified sexual problems with Helen as a high-priority issue. Almost immediately, the couple was seen twice monthly; these sessions alternated with individual sessions with Betty.

Betty was a 37-year-old woman who had been married for 16 years to a physically abusive man who raped her routinely. Helen, who was 28, was Betty's first female lover, but Betty reported that she had always had sexual feelings toward women and that when she began the affair with Helen it felt so "right" that she almost immediately began to identify herself as a lesbian. Helen had identified herself as a lesbian since adolescence and had had several female lovers prior to meeting Betty.

Betty and Helen had become lovers while Betty was still married; she left her husband 1 year later. Both women agreed that their sexual relationship was initially intense, frequent, and satisfying. However, since they had begun living together, the frequency had declined to twice a month. The couple agreed that the decline in sexual frequency was due to Betty's loss of sexual interest.



The first two or three couple sessions were spent attempting to get a clearer picture of the problem; Betty had a good deal of difficulty even talking about her feelings. She reported that she sometimes had "flashback" experiences of rape during sex; she was unable to experience orgasm with Helen; and sexual touching had become painful. Upon considerable probing, she revealed in Helen's presence that she actually experienced no sexual desire and that she had sex with Helen only because she was afraid Helen would leave her if they didn't have sex at all. Helen was crushed by this revelation. Considerable therapy time, at this juncture and throughout treatment, was spent in dealing with Helen's feelings of rejection, demoralization, and finally anger not only that Betty did not want to have sex with her but that she had consented to sex and then afterward revealed that she had not wanted it.

This theme emerged as a crucial one for Betty. She was almost incapable of saying "no" to sex, because she felt she would be abandoned by her partner. A "ban" on genital sex was instituted, which initially produced great anxiety in Betty but eventually was a relief to both women. During any homework exercises, however, Betty invariably completed the assignment and then reported that she had felt uncomfortable during the exercise but felt unable to articulate her desire to stop. It appeared that Betty had come to feel that neither her body nor her sexuality "belonged" to her. Both were simply instruments of her partner's desire, and even though Helen was quite unlike her abusive husband, Betty was so convinced that sexual performance was essential to the maintenance of Helen's love that she manufactured her own pressure. Helen was very clear in asserting that she did not want Betty to "pretend" to be sexually responsive. Betty's sexual desire had become lost in the demand requirements for sex. As Betty explained at one point, "You can't feel free to say 'yes' unless you feel free to say 'no.'"

A secondary theme that emerged was Betty's history of sexual abuse, and a resulting pattern common in women with a background of sexual assault and/or incest. During the "honeymoon period" of her relationship with Helen, Betty's sexuality seemed free, spontaneous, and strong. Once the limerance stage began to pass, older sexual conflicts and issues emerged. This became clearer as I guided the couple at an excruciatingly slow pace through sensate focus exercises. The goal with sensate focus was to use the exercises as a tool for uncovering negative thoughts, feelings, or images that might be blocking Betty's sexual desire. They worked well for this purpose; during homework assignments, Betty became aware of very specific fears, and re-experienced them vividly during sessions. For example, during one session, when Betty was reporting her feelings during an exercise involving breast touching, she burst into tears and asked Helen, "Were you going to pinch my nipples? I thought you were going to hurt me." These fears usually represented actual events that had occurred during her marriage; they were so "alien" for Betty that she lost some ability for reality testing, and feared

that Helen would repeat this assaultive behavior despite evidence to the contrary. Besides sensate focus and similar exercises in couple sessions, Betty worked on these fears and images in individual sessions. She proved a good trance subject, and so hypnotherapy was used extensively—both to help her uncover, relive, and resolve her marital experiences, and to help her get in touch with and express rage toward her ex-husband.

Meanwhile, unexpectedly, the couple's sessions began to stimulate Helen to uncover some hidden sexual conflicts. She revealed a history of incest with an older brother, and these memories became increasingly vivid to her as therapy progressed. About 1 year after the conjoint treatment began, Helen sought individual therapy with another therapist and joined a peer support group for incest "survivors." Shortly after this, Betty, in individual therapy, began talking about a childhood sexual episode with an older boy in her neighborhood; she had mentioned this at the beginning of treatment but had dismissed it as unimportant. In working through this early experience, it appeared that in many ways her relationship with her husband, especially the rape episodes, was a repetition of this early childhood relationship, with one exception. She had been a partially consenting participant in the childhood experience, and became aware of feelings of guilt and shame about these childhood contacts. In other words, she did not simply feel like a "victim"; underlying her "victim" feelings were intense feelings of guilt and self-blame—first, for her complicity in the childhood events, and more globally over any sexual feelings she had.

At the time of this writing, Betty and Helen are still in treatment and have been for 18 months. It took over a year for the women to resume genital sexual relations with each other. Their sexual contact now is infrequent, but both report that, when they have sex, they are unambivalent and it is satisfying to both. While Helen is actually experiencing lower desire than Betty at this point, she is intensely involved in dealing with her own incest experiences. It remains to be seen whether continued therapy can help these women to recapture a spontaneous and relatively conflict-free sexual relationship.

#### Miriam and Diane: A Case of Low Success

Miriam was the 28-year-old lesbian discussed earlier in this chapter, whose low sexual desire issues, when uncovered, yielded to feelings of intense, specific, and ego-dystonic sexual impulses. Ultimately, I consider this case a failure; the reasons constitute an interesting lesson in the systemic function low desire may serve.

Miriam and Diane were seen individually and jointly for 1½ years. Miriam contacted me upon referral from her individual therapist, who continued to see her weekly throughout the time I worked with Miriam. I

saw Miriam alone for the first few sessions, in part because Miriam reported her problems to be purely individual. Moreover, I never saw Miriam or the couple together more frequently than once or twice a month; both were in individual therapy with other therapists, and they traveled a substantial distance to see me. The infrequency of meetings undoubtedly affected treatment, but under the circumstances it seemed the only arrangement possible.

Miriam was attractive, always slightly nervous, and moderately overweight. Both she and Diane considered themselves compulsive overeaters and were members of Overeaters Anonymous; both had the rigidity one sometimes encounters in new members of Twelve-Step programs. Miriam initially reported low sexual desire, an inability to experience orgasm with a lover, and a physical feeling of "numbness" when touching during sexual encounters. Despite her antisexual upbringing, she had begun masturbating at 13, and her first sexual experiences with both men and women had occurred in late adolescence. Her attraction to women was stronger than that to men, however, and her sexual contact with men was incidental after her first affair with a woman at age 19. Miriam stated that shortly after this affair ended, she began to feel "afraid" of sex. This fear expressed itself in difficulty reaching orgasm with a partner; an aversion to masturbating (although orgasm during masturbation was not a problem); and a pattern of high sexual desire in the beginning of a relationship, followed by a sharp decrease in desire and arousal after a few months. Miriam and Diane had been partners for 2 years at the time therapy began. Miriam reported that it was her best relationship so far.

Almost immediately, Miriam reported tremendous fear of loss of control over her sexuality. Initially this was expressed as fear of orgasm, but the fear of urinating in bed was reported in her second session. Much early work was focused on this fear and upon the "numbness" she described. Miriam was asked to masturbate as homework; she was requested to "pretend" orgasms to diminish the fear; she was instructed to use a "stop-start" exercise when she began to feel numb during arousal; she was asked to urinate in bed, but she refused. In the first few months, therapy centered on her antisex injunctions. She generated a list of her internalized "rules" about sex (her "rules" included messages about when to have sex, as well as with whom, how, etc.), and then she was asked to set about breaking them one by one. She read Barbach's book *For Yourself* (1975) and did mirror exercises and genital touching exercises. All this seemed to have some impact. Within the first 2 months she had her first orgasm during sex with Diane, although this rarely occurred afterwards. She began to report more arousal and desire.

Four months after Miriam began individual treatment, Miriam and Diane were seen together. Diane presented herself as well adjusted and sexually robust, and extremely patient and supportive of Miriam. Miriam

was Diane's first female lover, but Diane appeared to be experiencing no difficulties with her lesbianism. Diane's family background was bizarre: One sibling was schizophrenic, and Diane's mother had left the children in their adolescence in order to join a convent. Nevertheless, Diane appeared to be much the healthier of the two women. Diane's aid as a quasi-surrogate for sex was enlisted in order to have the couple participate in sensate focus exercises.

The combination of individual and conjoint sessions seemed to work well. Miriam gradually became more sexual; as she did so, she began to be aware of more specific sexual fears. Fantasies of domination and submission began to appear to her in a way that seemed invasive and intrusive, and she also became terrified that she would "commit adultery." In addition, as couple therapy progressed, Diane began to express sexual fears for the first time. She became aware that she was uncomfortable with their increasing sexuality, and traced this to a fear of intimacy and especially of abandonment. Although we discussed these fears, I feel in retrospect that they were probably more important than seemed apparent at the time. The couple was encouraged to introduce sexual enhancement techniques into the relationship, such as the use of vibrators and other sex toys, written and visual erotica, and so on. Miriam was again asked to deal with her fear of urination directly by urinating in bed. As described earlier, this intervention "worked" in that it produced a powerful orgasm followed by a flood of strong sexual feelings, which Miriam then had to learn to control. However, Diane's sexual desire had been gradually lessening, and as Miriam became more sexual Diane became noticeably less so. Moreover, at about the time of Miriam's breakthrough, Diane received a devastating letter from her mother condemning her to "hell" for her lesbianism.

In the next few months, Diane became completely asexual and sank into a depression that required treatment by means of medication. Again, the couple's genital sexuality disappeared, and as this happened, Miriam reported that *her* sexual desire was diminishing. Shortly after this, the couple terminated treatment. In retrospect, it is possible that insufficient attention was directed at the system dynamics that were functioning to keep both partners asexual. In particular, Diane's individual conflicts were underestimated, and in dealing with this problem as an individual therapy problem for Miriam, the relative contribution of the partner was ignored.

### Conclusion

This chapter has focused upon low sexual desire in lesbian couples as a prototype for sexual issues in all women. The social-constructionist view has been advanced that female sexuality, while distinct from male sexual behavior, is primarily the result of cultural conditioning rather than fun-



damental biological differences between men and women. Lesbian sexual desire problems, which are almost entirely problems encountered in relationships of committed couples, are seen as the consequence of female-female pairings and the concomitant exaggeration of traits socialized in women. Various theoretical issues arising from this perspective are discussed, and specific causes and interventions are described.

The approach described in this chapter assumes that female sexuality as conditioned in this culture includes some features that are negative, self-defeating, and inhibitory of full sexual functioning. The perspective taken, therefore, implies that at least some women would benefit from therapy that helps expand or "disinhibit" their sexuality. It could be argued, however (and has been argued by both sexologists and feminists), that female sexuality as it currently manifests itself is "natural" and that therapeutic interventions should therefore focus on redefining "male-identified" cultural norms for sex rather than on changing women's sexual behavior. While this latter viewpoint is not the stance taken here, we would do well to remember that, for some women, redefining their problems as normal behavior may be more efficacious than attempting to change them.

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