

CHAPTER 14

Therapy with LGBTQ¹ Clients

Working with Sex and Gender Variance from a Queer Theory Model

Margaret Nichols

We do not even in the least know the final cause of sexuality.
The whole subject is hidden in darkness.

—CHARLES DARWIN

I argued that psychiatric diagnosis was the child of morality and
that Judeo-Christian values controlled psychiatric practice.

—GAY PSYCHOLOGIST CHARLES SILVERSTEIN (2009),
referring to the 1973 removal of homosexuality
from the DSM

Deviant or different? Sex therapy has moved beyond this question for individuals who identify as members of a sexual minority, defined in this chapter as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Members of sexual minorities now seek sex therapy not for help in changing or accepting their orientation but for help improving their sexual satisfaction. Although many of the sexual problems may be the same

¹LGBTQ: lesbian, gay, bisexual, transgender, queer. “Queer” includes other sex/gender variations, such as BDSM and polyamory, or is used by some to indicate membership in more than one sex/gender minority.

(e.g., low desire, anorgasmia), Nichols cautions us not to apply heterosexual standards of normal, ideal, or healthy sexuality to our treatment of sexual minority clients; in other words, "All forms of sex and gender variance are innocent until found guilty." Nichols places sex therapy for sexual minorities in historical and cultural context and raises basic questions about the nature of sexuality, such as: What constitutes a sexual orientation? Is sexual orientation static? Why is monogamy privileged over other sexual arrangements? Above all, Nichols encourages clinicians working with sexual minority clients to keep an open mind and to be flexible in both the method and goals of treatment.

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The first edition of *Principles and Practice of Sex Therapy*, published in 1980, contained a chapter on gay male sexuality written by David McWhirter, MD, and Drew Mattison, PhD. It was provocative for its time because even though homosexuality had been officially removed from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, many sexologists and sex therapists were not fully on board with this idea. Masters and Johnson (1979) had just published a book purporting to "cure" homosexuals, and Helen Singer Kaplan (1979) had claimed that same-sex orientation was a form of desire disorder. Yet Leiblum and Pervin (1980) chose two openly gay men for a chapter showcasing solid, long-lasting—and nonmonogamous—gay male relationships.

Starting in 1989 with the second edition of *Principles and Practice of Sex Therapy*, I have written the "queer chapter" as an openly queer sex therapist running a therapy agency specializing in work with the LGBTQ community.² Over the years the queer subculture has grown more inclusive: In 2013 "the community," virtual and in the flesh, contains not only people who identify as LGBTQ but also those interested in BDSM, fetishes, and nonmonogamy. Because of this, in this chapter I address LGBTQ issues as well as polyamory/nonmonogamy, leaving BDSM to Kleinplatz (Chapter 9). I define "sex therapy" as not only the treatment of sexual dysfunction but also what it has been historically, treatment of those with atypical sexuality or gender expression, and I cover both types of issues here.

²The chapter in the fourth edition is coauthored with my dear late friend and colleague Michael Shernoff.

THE PATHOLOGY MODEL AND ITS SOCIAL CONSEQUENCES

From the birth of sexology, marked by the publication of Kraft-Ebbing's *Psychopathia Sexualis* in 1886, sex researchers and their psychiatric colleagues have been concerned, one might even say obsessed, with atypical sexual behavior and gender presentation. And since that time, there have been two competing views of nonstandard sexual behaviors: the belief that these behaviors and attractions are deviant and the view that they are simply variant. Kraft-Ebbing favored deviance, whereas Havelock Ellis and Magnus Hirschfeld saw variance; Freud framed deviant sexuality as developmental immaturity, whereas Kinsey imagined the natural variation found in his original field, entomology (Drescher, 2010).

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* codified our understanding of sex and gender variance with its first edition in 1952 (Grob, 1991). Dominated by psychoanalytic thought, grounded in psychiatric opinion rather than, for example, the scientific work of Kinsey, the diagnosis of OOQ-x63, Sexual Deviation, included descriptors and subtypes ranging from homosexuality and transvestitism to nymphomania and syphilophobia (fear of syphilis). We now see some of these diagnoses as ridiculous, but at the time psychiatrists saw them as true mental disorders.

Biological theories now rival or overshadow psychoanalytic ones in psychiatry and sexology, but both models are rooted in the assumption that procreation is the sole or primary function of sex. This belief in turn issues from a narrow interpretation of Darwin's theory of sexual selection, for example, "survival of the fittest," the idea that the transmission of desirable genetic traits is accomplished when the fittest male and fittest female mate and produce offspring. This model makes heterosexual intercourse a biological imperative, whereas sex or gender presentations that do not lead directly to reproduction are "evolutionarily maladaptive" (Bailey, 2003, p. 115) or a "developmental error" (Bailey, 1999, p. 884).³ In the deviance model, statistically unusual forms of sex and gender are mistakes, whether diseases caused by birth defects (biology based) or immature development (psychoanalytically based). And if they are mistakes, if possible these atypical forms should be treated and cured. Just as the medical model upon which psychiatry rests views deviations from the norm as disease indicators, so by extension sex and gender outliers are abnormal as well.

The deviance model became incorporated into the new field of sex therapy, the clinical application of sexology science. The leaders in the field,

³In fact, there is a virtual cottage industry of evolutionary psychological theories just to explain homosexuality, because according to a strict Darwinian model, genes for homosexual behavior should have vanished cons ago.

Masters and Johnson and Helen Singer Kaplan, clearly saw homosexuality as less desirable than heterosexuality; besides their books, these pioneers played deplorable roles in the AIDS era of the late 1980s, exaggerating the risks of transmission, spreading misinformation about gay men, and amplifying the heightened homophobia of the nation (Irvine, 2005).

Although sexologists and psychiatrists assume that their work is neutral and above the fray of social norms and customs, history shows us that the opinions of these experts have enormous social consequences, intended or not. The pathologization of homosexuality by sexologists in the 1800s is widely credited with bringing about increased social oppression of same-sex people, including the criminalization of sodomy (D'Emilio & Freedman, 1988). In the first part of the 20th century, homophile activists, ironically, turned to psychiatry in the hope that being classified as "mentally ill" rather than criminals would soften public opinion, only to find that their psychiatric status became the justification for other forms of discrimination, particularly employment (Hirshman, 2012). As the Silverstein quote that starts this chapter suggests, so clearly was psychiatry seen as the enemy that the Gay Activist Alliance demonstrated at the American Psychiatric Association (APA) meeting within 6 months of the "Stonewall Revolution" that started modern gay activism. And the removal of the diagnosis in 1973 was instrumental in changing the public image of homosexuality (Bayer, 1981; Drescher, 2010). Although the APA, pushed by the activists, did not see the change as an endorsement that homosexuality was "normal," it was widely interpreted that way, and this helped efforts to overturn the criminal and civil laws founded on the view that gays were mentally ill. The practice of therapy changed: Involuntary hospitalization and aversive conditioning techniques, formerly routine, were abolished and attempts at "cure" mostly discredited. The declassification reinforced "gay pride" and helped diminish shame and self-hatred (Bayer, 1981). In part because of the APA decision, lesbians and gay men in the United States have achieved a remarkable degree of acceptance in a few decades.

Although the removal of the diagnosis in 1973 was a victory, Silverstein (2009), who was one of the activists involved, acknowledges that it fell far short of their goal of removing all "sexual deviancies" from the DSM. It by no means signaled the fall of the pathology paradigm: Even psychiatrists who favored removal believed that homosexuality was inferior to heterosexuality (Bayer, 1981), and as recently as 2012 sexologists could wonder whether homosexuality was a "paraphilia" (Cantor, 2012).

Thus debates about "cures" for homosexuality continue to rise up periodically. Although "conversion therapy" became scientifically discredited and homosexuality largely seen as "inborn," Christian Right groups in the United States still consider homosexuality a (sinful) "choice." Some have continued to try to change sexual orientation via what is called "reparative" or "ex-gay" therapy. In 2003, prominent psychiatrist Robert Spitzer, a leading proponent of the 1973 DSM decision, published an article reporting the success of ex-gay treatment (Spitzer, 2003), which was published in the prestigious *Archives*

of *Sexual Behavior* without peer review. Spitzer's study was widely used by Christian ex-gay groups to justify their treatment methods.

The reparative therapy issue made headlines once again in the spring of 2012, when journalist Gabriel Arana published an account of his own ex-gay therapy. During an interview Arana obtained for the story, Spitzer admitted that "he had been wrong" in his conclusions in the 2003 study (Arana, 2012). Later, Spitzer made public a letter to the *Archives* retracting his 2003 views and a video apology to the gay community (Besen, 2012). But Spitzer's rationale for his apology was simply the ineffectiveness of conversion therapy. Despite his 1973 advocacy of removal of the diagnosis, Spitzer never saw gayness as normal. Says Hirshman (2012): "To this day, Spitzer thinks there's something not optimal about homosexuality, a behavior that does not lead to survival in a simple Darwinian world" (p. 140).

A QUEER THEORY OF SEX AND GENDER VARIANCE

I write as an openly queer therapist, the director of an LGBTQ psychotherapy center since 1983. But the model I describe here reflects the views of many of my LGBTQ-oriented peers and increasing numbers of leaders in sexology and mental health. The American Psychological Association Practice Guidelines for LGBTQ clients state that "same-sex attractions, feelings and behavior are normal variants of human sexuality" (2012, p. 14). The World Association for Transgender Health (WPATH) endorses a "normal variance" model, and the *International Classification of Diseases* (ICD) codes of many European countries already reflect the WPATH guidelines. Some European countries have also eliminated consensual paraphilias from the ICD. The following paradigm is mine, but it is not unique.

An important subtext of the queer model I describe is a postmodern view of science. Queer theorists assume that science is never unbiased, that it is always distorted by the often unarticulated beliefs that the entire culture takes for granted to be true, even when it seems to be completely "objective." Consider this *Scientific American* report on song sparrows, birds that form long-lasting pair bonds to rear offspring but are sexually nonmonogamous (Fecht, 2012). Biologists describe the birds as "cheating" and "promiscuous" and label their behavior "infidelity." If a "hard" science such as biology is so clearly biased by cultural beliefs, queer theorists reason, the "softer" social sciences are hopelessly skewed. Queer theory considers history, sociology, direct observation, and clinical experience as data sources equal in significance to experimentally designed research.

Here are some fundamental assumptions of the queer theory paradigm:

- *Sex and gender variance is part of evolution's plan.* The traditional interpretation of Darwin is being challenged more and more in biology (Bagemihl, 1999), evolutionary science (Bailey & Zuck, 2009; Roughgarden,

2004) and psychology (Ryan & Jetha, 2010). Noting the lack of evidence to support the traditional mate-competition hypothesis and the observed fact that most sexual acts engaged in by animals are nonprocreative, dissenters suggest that sexual behavior is multipurposed and for many animals functions as an affiliative tool more often than a mechanism of reproduction. Thus, “recognized as a way to build and maintain a network of mutually beneficial relationships, nonreproductive sex no longer requires special explanations” (Ryan & Jetha, 2010, p. 103). Because “normal” sex does not have to be procreative, heterosexual intercourse and a rigid binary system of gender are not privileged.

- *All forms of sex and gender variance are innocent until found guilty.* If sex and gender variance are part of natural design, then they are presumed useful, even necessary, unless proven otherwise. This concept is in direct opposition to the psychiatric model that considers outliers problematic, and the clash of these beliefs has produced the ongoing hostile relationship between psychiatry/sexology and the LGBTQ community. What psychiatry sees as suboptimal adjustment, LGBTQ people consider normal and benign. Diagnosis, cure, and treatment is not only unnecessary, it is oppressive to sex and gender atypical people, who consider themselves in need of civil rights, not mental health intervention. A graphic on *GIDreform.org* is labeled “Let Us Out” and shows three trans people “escaping” from the DSM.

- *Our current knowledge of sex and gender variance is primitive; we don't yet know what dimensions are relevant.* For example, our current Western model assumes that sexual orientation and gender identity are completely separate dimensions, but many other cultures, including our own less than 100 years ago, see them as blended or even identical. The very way we “slice up the pie” may be wrong, and contemporary research on sex and gender may largely turn out to be irrelevant, like the old Greek medical concept of “vapors.”

For example, there is current dialogue within the LGBTQ community—and confusion among professionals—about what constitutes an “orientation.” Some nonmonogamous people, many kinky people and some self-identified asexuals experience their respective sexual desires as outside of conscious control, compelling, and organic, that is, something that has “always” been part of them. We have no tangible definition of “orientation,” which traditionally has referred only to same- or opposite-sex attraction. Do sex- and gender-variant people share common underlying traits that might represent dimensions of sexuality we have yet to consider? And think of our different measurements: Does “orientation” reference desire, fantasy, behavior, or self-identification? To queer theorists, our current category constructs must be thought of as working models, not “reality.”

- *Variant forms of sex and gender expression have existed in all cultures since the beginning of human existence.* Exhibit 1: the “gay caveman” (Gast & Aarthun, 2011). Interestingly, these are actually the remains of a gender-variant but not necessarily same-sex-attracted individual.

- *Biology may predispose toward sex and/or gender variance, but culture determines the extent to which it will get expressed and the ways it may manifest.* The interdisciplinary approach favored by queer sexologists makes us appreciate the vitally important role of culture. We understand that different cultures determine whether sex and gender variance will be permitted any open expression at all and, if permitted, what forms are sanctioned (Eliaison & Schope, 2007; Nichols, 2012). Iran exemplifies extreme cultural shaping: The country ranks second worldwide in its rate of gender reassignment surgery (GRS; Drescher, 2010) with little (open) expression of homosexual behavior, because in Iran homosexuality is a crime punishable by death, and GRS is sanctioned and funded by the state.

Even in cultures in which same-sex attraction has been allowed, its expression has taken many forms. Our 21st-century Western model of homosexuality is far from universal. We define orientation by the gender of one's partners, but in many cultures the particular sexual acts engaged in, and the role one plays during sex, are more important. For example, Brazilian "travesti" have a feminine gender presentation but keep their penises and are sexually involved with other men (Phua, 2010), and in Mexico a homosexual is defined as being the person who is the "insertee" in sex and bisexual behavior is accepted in heterosexually identified "inserters" males (Jeffries, 2009). In Western First World countries, egalitarian relationships between self-identified gay people are the norm, but age-structured relationships between older men or women and young boys or girls are most common historically and still exist in some non-Western cultures. Culture affects whether sex and gender variance is expressed openly, how much it is stigmatized, and what lifestyles and identities are available to variant people.

- *In Western culture, sex and gender expression are also determined by the LGBTQ subculture.* Unlike other minorities, LGBTQ people usually have sex- and gender-normative parents who may not support their children, and often this spurs the formation of communities that take the place of family. The LGBTQ subculture provides a "tribe" that validates, protects, and nurtures its members against a hostile mainstream, and like all tribes it has its own norms, philosophies, and beliefs that determine available identities—how one can self-label—and permitted behaviors. Most important, the LGBTQ subculture continuously evolves. In North America and Western Europe it has evolved and morphed at warp speed in the past 40 years. I discuss current trends in the LGBTQ community later in the chapter.

- *It's not "dysphoria," it's "minority stress."* Consistently higher rates of depression, suicidality, and substance abuse have been solidly documented among LGBTQ people for at least three decades (Mustanski, Garofalo, & Emerson, 2010). LGBTQ teens are twice as likely to use alcohol or drugs as their heterosexual peers and half as likely to report that they are happy, and they are more likely to report eating disorders, self-harm, depression, or suicide (Human Rights Campaign, 2012). Proponents of a deviance model have suggested that elevated rates of mental disorders are genetically linked to sexual

orientation or gender atypicality (Bailey, 1999). In contrast, queer theory sees an LGBTQ person's dysphoria as the result of "minority stress." Borrowed from research on racial and ethnic minorities, the concept of "minority stress" refers to the physical violence, legal sanctions, discriminatory practices, and social disapproval that members of stigmatized groups routinely encounter in their lives. There is a substantial body of research linking minority stress and LGBTQ mental and sexual health (Herek & Garnets, 2007). LGBTQ people who live in states that have banned gay marriage exhibit elevated rates of psychiatric disorders after passage of the laws (Hatzenbuehler, Rosario, Corliss, Koenen, & Austin, 2012), and among transgender people depression is directly linked to the extent to which they have suffered abuse because of their atypical gender presentation (Roberts et al, 2012). School victimization fully mediates the relationship between LGBTQ youth and depression (Toomey, Ryan, & Diaz, 2010).

Minority stress affects different LGBTQ subgroups differentially, with the most stigmatized subgroups suffering the most. Gender-variant people and bisexuals appear to have the highest rates of depression, suicidality, sexual assault history, and sexual health problems (Mustanski et al, 2010). Black LGBTQ people suffer more than whites; black gay and transgender youth are more likely to end up homeless, for example (Yu, 2010). The queer model asserts that LGBTQ people do not suffer psychological distress because they are variant but rather because society can't handle their variance.

- *Families do not create sex and gender variance, but their reaction to their variant children greatly influences the young person's mental health.* Supportive families and schools can reduce minority stress. The top reasons depressed and suicidal LGBTQ teens give for their distress are family rejection and LGBTQ-related victimization by peers and others (Diamond et al., 2011). Family acceptance seems to be a "buffer" against extrafamilial stressors (LaSala, 2010; Kuper, Nussbaum, & Mustanski, 2012).

DSM-5: A CLASH OF PARADIGMS

The revisions to DSM-5 (American Psychiatric Association, 2013) include two areas of great concern to the LGBTQ community: diagnoses about gender atypicality and the paraphilias. I address only the first here.

When the diagnosis of gender identity disorder (GID) was added to DSM in 1980, transgender people hoped it would lead to increased access to medical care, but over the years most transgender activists came to view GID as the equivalent of the psychiatric diagnosis of homosexuality, a tool of social control (Lev, 2005). Since the publication of the first Harry Benjamin Society Standards of Care (SOC) in 1979, mental health practitioners have been gatekeepers for hormone treatment and surgery, and as such they have sometimes denied or blocked access to medical treatment based on their interpretations of the SOC. Certain theories, such as the theory of autogynephilia, have caused concern among the transgender community that people who fit this definition

will not be seen as “true” transsexuals, and thus they will be denied access to medical treatment. As transgender people feel more empowered, they are becoming more vocal: At the 2009 American Psychiatric Association meeting, transactivists protested the composition of the DSM-5 Work Group on Gender Identity Disorders (Peggy Cohen-Kettenis, chair, Heino F. L. Meyer-Bahlburg, Jack Drescher, Friedemann Pfafflin), complaining in particular about the lack of transgender representation and Kenneth Zucker’s leadership, as Zucker’s therapy methods with gender-variant children has been a target of such activists (Wingerson, 2009). Transactivists continue to protest the GID, gender identity disorder in children (GIDC), and TD (transvestic disorder) diagnoses. Many providers of transgender care have joined them, and as a consequence, the renamed Harry Benjamin Society—the World Professional Association for Transgender Health (WPATH)—version of the Standards of Care released in 2011 radically depart from past editions, changing the role of the mental health professional from gatekeeper to advisor/advocate (Knudson, Cuypere, & Bockting, 2010) and asserting that “gender variance is not in and of itself reflective of pathology and having a cross- or transgender identity is not a psychiatric disorder” (Knudson et al., 2010, p. 116). WPATH has recommended that the World Health Organization change the name of GID and GIDC and move them out of the psychiatric disorder classification and into one of medical disorder; many European countries have already done so. Meanwhile, many LGBTQ counseling centers and health clinics have already rejected the “gatekeeper” model and offer hormones to those who can give informed consent without the recommended letter from a mental health practitioner (Drescher, 2010).

GIDC has been a controversial diagnosis as well. The primary issue has been the recommended treatment for these children, which, until recently, consisted of getting them to become more behaviorally gender conforming. The WPATH SOC now considers this treatment unethical. Instead, WPATH endorses support for younger children and a protocol of medical treatment beginning in early puberty that has been in place in the Netherlands for 20 years (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Increasingly, queer-theory-based practitioners and parents of gender-variant children, allied with LGBTQ groups, are demanding this medical treatment and/or social transition for gender-variant children and teens (Ehrensaft, 2011). Mental health professionals practicing within the traditional paradigm are resistant, urging “caution” (Levine, Zucker, & Meyer-Bahlburg, 2012), and in the United States it has primarily been nonpsychiatric M.D.s who have replicated this treatment modality, with apparent success (Spack et al., 2012).

EMERGING TRENDS IN THE LGBTQ COMMUNITY TODAY

In 2013, there are breaking trends in behavior and self-identification in the LGBTQ urban communities that will eventually affect all queer communities

in North America. Professionals working with this community need to stay abreast of changes; here are some that have relevance to sex therapists and sexologists:

- *Gender lines are blurring.* Transgender people have increasingly become incorporated into the LGBTQ subculture. Transwomen who are attracted to other women identify as lesbians; transmen attracted to women often partner with bisexual women and remain within the LGBTQ community. This integration of trans people into the queer subculture has produced a new way of viewing gender: rejection of the gender binary in favor of a continuum. This in turn has resulted in a proliferation of new gender identities, especially among women. In truth, there has always been an overlap between gender identity/expression and sexual orientation, for example, “butch” lesbians and “sissy” gay men, despite the politically correct trope that they are separate. Lesbians, who historically have eroticized “butchness,” have ultimately embraced transmen, and the younger ones have enthusiastically adopted newly emerging identities. Dykes and butches have been joined by those who identify as bois, AG’s, genderqueer, gender fluid, or just plain queer. It is probable that the acceptance of “butchness” within the lesbian community has helped drive the explosion of female-to-male (FtM) transmen. Once thought to be uncommon, FtMs now equal male-to-female (MtF) transgender people in number (Beemyn & Rankin, 2011), and two-thirds of FtMs first identified as “butch” lesbians. Gender identity and sexual orientation are blending in new and unexpected ways: There are FtMs who are only attracted to other FtMs, bisexual women just attracted to transmen or transwomen, and FtMs who pretransition were only attracted to women but afterward are attracted to gay men and self-identify as gay male (Bockting, Benner, & Coleman, 2009).

Transgender people themselves are choosing more “blended” identities, eschewing the former labels of “transsexual” and “cross-dresser.” In fact, among those under 40, “genderqueer” is the single most commonly chosen identity label (Beemyn & Rankin, 2011). As the binary has broken down, so has the traditional trajectory of hormones, full transition to the “other” gender, and GRS. Providers used to the psychiatric model become confused when, for example, a young FtM wants chest reconstruction surgery but eschews the use of testosterone, and yet this is becoming increasingly common.

- *The overlap increases.* As transgender people become incorporated into the LGBTQ community, so have others whose sexual expression is variant from the mainstream. Alliances between BDSM and polyamory⁴ activists

⁴Polyamory is a specific form of “open” relationship, espousing multiple sexual and romantic partners, unlike “swinging” and typical gay male open relationships, both of which emphasize sex and not intimate connection. In practice, the boundaries between these types of open relationships can get blurred.

and LGBTQ groups are growing, and there is increasing overlap between all groups. Gay men, lesbians, and especially bisexuals are overrepresented among those who are interested in nonstandard sexual practices and open relationships (Richters, de Visser, Rissel, Grulich, & Smith, 2008; Barker & Langdridge, 2010). The professional used to working with one group will increasingly need to be aware of all types of sex and gender atypicality.

- *The notion of fixed identity and orientation is changing.* Sex- and gender-variant identity is more fluid than we have imagined, perhaps more for women than men (Diamond, 2008). Moreover, the very meaning of identity may be changing. Most sexologists regard identity as a fixed, essential quality of the individual. But Lisa Diamond, who followed a cohort of self-identified bisexual and lesbian college women over nearly 12 years, found that her participants changed identities two or more times, using the labels more as descriptions of their current lives than unchangeable attributes. Increasingly, many younger sex- and gender-variant people feel that *no* identity label captures their experience (Savin-Williams, 2005). One such person's self-description is "first as a guy, then as a gay man, then as an FtM, then perhaps. . . as a queer FtM who still has sex with women (usually butch women or MtFs) once in a while" (Bockting et al., 2009, p. 693).

CLINICAL ISSUES

Assessing with Whom You Are Working and What the Sexual Problem Is

Not all nonheterosexual clients will self-identify as gay, lesbian, bisexual, or transgender, so it is important for the clinician to recognize the relationship between self-proclaimed identity and other measures of sex and gender variance, such as attractions, fantasy, or behavior. In any society that stigmatizes homosexuality, many more people will *experience* same-sex attractions than will *act* upon them, and fewer still will *identify* as gay, lesbian, or bisexual (Chandra, Mosher, & Copen, 2011). Also, when gender nonconformity is vilified, people attempt to hide their atypicality. Therefore, heterosexually identified people may have same-sex desires and behavior (Reback & Larkins, 2010), and some clients who appear to be cisgendered⁵ have internal feelings of gender incongruence. Because gay people have historically had difficulty with bisexuals, self-identified lesbians and gay men may have extensive heterosexual experience that they hide. And the label "bisexual" is itself complex—it is a residual category that includes people who have little in common besides an attraction to both sexes. There are bisexuals who are monogamous, those who consider bisexuality and polyamory intrinsically linked, individuals with

⁵"Cisgender" = the opposite of transgender. Cisgender people experience their gender as congruent with their body, presentation, traits, and behaviors and with others' experience of them.

equal attraction to both genders, those with a primary attraction to one gender, and some who feel their desires transcend gender.

To capture this complex information and to avoid offending LGBTQ clients, who usually notice language based on the “heterosexual assumption,” initial assessment tools need to be gender and sexual orientation neutral. Include the option of “other” when asking about gender, ask for information about the client’s partner instead of “husband” or “wife,” talk about vaginal penetration, not intercourse. Information about multiple dimensions—attractions, fantasy, behavior, and self-identification—should be ascertained separately and examined for incongruencies. When present, incongruencies should be explored gently: A client’s identity may seem at odds with his or her behavior or attraction, but it symbolizes an important, deeply held belief the person holds about him- or herself. As a clinician, you may suspect that the man sitting across from you, who regularly has sex with other men but identifies as heterosexual, is fooling himself, but it may take years before the client can come to terms with that—or it may never happen at all.

There are no widely used instruments measuring sexuality and sexual dysfunction that are geared to LGBTQ clients. Most existing tools focus on heterosexual intercourse as a measure of sexual function, so clinicians working with LGBTQ clients will need to design their own instruments.⁶ The sexual questionnaire we give clients at the Institute for Personal Growth (IPG) includes questions about more than two dozen sex acts, including some “kinky” and “fetish” acts, questions about male and female sex partners, and questions about open, consensual outside sexual activity, as well as about “infidelity.” Therapists should be aware that despite such TV shows as *Modern Family*, LGBTQ people do not all model their sex and relationship lives according to heterosexual norms. As previously noted, BDSM and open relationships are quite common in LGBTQ populations, especially among younger people in urban areas.

For LGBTQ clients in need of sex therapy, DSM-5 (American Psychiatric Association, 2013) diagnostic categories can be used without issue, as they are notably free of heterosexual bias in their wording. There are some specific sexual problems that LGBTQ clients may bring that are uncommon among heterosexuals and related to differences in sexual behavior—for example, an aversion to oral or anal sex. These may need to be classified as “not otherwise specified” (NOS) disorders in DSM-5.

Lesbian Sexual Issues

The sparse research on lesbian sexuality, mostly survey data, suggests that woman-to-woman sex is different from heterosexual sex in some important ways (Matthews, Hughes, & Tartaro, 2006; Nichols, 2006; van

⁶I will send electronic versions of my questionnaires upon request.

Rosmalen-Nooijens, Vergeer, & Largo-Janssen, 2008). Lesbians seem to spend more time on sex, incorporate a larger sexual repertoire (particularly those acts commonly considered “foreplay”), are more frequently orgasmic when they do have sex, are less likely to have sex just because their partners want it, and report fewer pain disorders, lower overall rates of sexual dysfunction, and lower rates of STDs. Like their heterosexual female counterparts, the most common lesbian sexual complaint is lack of desire, although, unlike heterosexual women, lesbians are as likely to complain of lack of desire in their partners as lack of desire in themselves.

“Lesbian bed death” is a phrase that describes lesbian relationships that over time become devoid of genital sex, if not nongenital affection. The term emerged in the 1980 from within the lesbian community, and it has been discussed and debated ever since. Some critics (Rothblum & Brehony, 1993; Cole, 1993) challenge the belief that sex is needed for healthy relationship functioning, arguing that genital sex may be redundant in egalitarian, intimately connected relationships: “sex therapy currently assumes that the goal is to be sexual, whereas in some situations it is better simply to validate a ‘Boston marriage’” (Cole, 1993, p. 192). Others argue that lesbian bed death is a myth. The data on frequency is mixed, with some surveys showing lesbians having somewhat lower frequency than heterosexual couples (Nichols, 2006) and others no difference (Matthews et al., 2006). In any case, lesbian bed death appears to occur less often than the urban legend would have it. But the focus on sexual frequency may reflect a heteronormative bias. Frequency aside, it appears that when two women do have sex, it seems to be at least as pleasurable as heterosexual sex is for straight women, it lasts longer, contains more of the sexual behaviors many women desire, and is more likely to be consensual.

Whatever the truth about lesbian bed death, existing data indicate that low frequency or desire is the main, indeed virtually the only, sexual problem gay women report. Many, though not all, lesbian couples present in a distinct way: They often have high-functioning, physically affectionate relationships with minor nonsexual relationship problems. Therapists who are familiar with the ideas of David Schnarch and Esther Perel may posit that the intense togetherness of these relationships contributes to the loss of sex passion, and in these cases individuation of each partner may be a therapeutic goal.

When a lesbian couple presents with problems of low sexual frequency, before initiating treatment the clinician should probe the reasons for the complaint and explore motivation before agreeing to attempt to resurrect sex for the couple. Coles’s admonition is worth remembering: Some couples just need to have their lack of a genital sexual relationship validated.

Case 1: “Lesbian Bed Death”

Elle and Cara, together 12 years, came to sex therapy complaining that sex had dwindled to once or twice a year. Cara had been the first to lose interest,

several years into the relationship, whereas Elle's diminished desire appeared to be a reaction to repeated rejection. Recently, Elle had experienced a strong attraction to another woman. Although she did not act on these feelings, the experience made her realize how much she missed sex, and she insisted that the couple seek sex therapy. Cara agreed. The couple reported good intimacy in nonsexual aspects of their relationship, and though Cara was not experiencing active sexual desire, her love for Elle motivated her to try to regain libido. The therapist's first intervention was to teach Elle and Cara about Rosemary Basson's (Basson, 2000) alternative model of the female sexual response cycle, which conceptualizes female desire as typically moving from "active" to "receptive" in long-term relationships. The women were told that they could not rely on physical lust to propel them to sexual behavior. Lesbian relationships sometimes suffer from what might be termed the "Basson squared" effect: If both women lose active desire, then no one initiates sex at all. Educating the couple about the Basson model validated Cara's experience and helped Elle depersonalize Cara's rejection of her sexual advances.

Once they accepted that "sexual willingness" would need to replace "lust," the couple was disabused of their belief that sex should be spontaneous and convinced to make "dates." They were also encouraged to dress and behave seductively and flirtatiously. Both women were trained to foster "simmering": They were taught to make themselves ready for sex by consciously thinking and fantasizing about sex hours or days before "date night," thus facilitating arousal over time.

The couple needed to shed other romantic but unrealistic myths. For example, they believed that all sexual encounters had to end in orgasm for both partners and that orgasm had to result from partner stimulation. But Elle had a higher sex drive and easier arousal and orgasm than Cara. Cara recognized her own willingness to pleasure Elle if she herself did not feel the pressure to have an orgasm that made sex into work. Cara and Elle redefined sex as sensual and/or genital contact that might (but did not have to) result in orgasm for one or both partners and in which the orgasms might or might not be partner facilitated. This freed the couple to have more sexual encounters, and the overall frequency of their sex life increased in a way that gave pleasure to them both.

This couple had a sexual repertoire that included lots of touching, oral and manual genital sex, and occasional digital-vaginal penetration. Although varied, it had become routine, and therapy shifted to encouraging exploration of new territory. They spent a session with the IPG toy box—a collection of sex toys ranging from vibrators, dildos, and butt plugs, to feathers, bondage cuffs, and lube samples. The therapist explained the use of these toys in an enthusiastic and matter-of-fact way in order to dispel the women's anxiety and encourage a playful stance toward sex, and afterward the women accepted a "homework" assignment to purchase some sex toys together. Because the therapist believed that "kinky sex," far from being pathological, could be an enhancer of sex, the women were asked to "interview" each other using copies

of sexual negotiation questionnaires developed by BDSM groups, documents promoting open, specific communication about sexual likes and dislikes. The use of a BDSM questionnaire might have been a risky intervention with a heterosexual couple, but given the acceptance of kink in the lesbian community, these women found it unremarkable. The exercise was successful and led the women to experiment with dominant–submissive role play. Thus BDSM introduced a power and role differential in this couple's sexual dynamic that did not exist in the rest of their relationship, and this individuation may have fueled erotic desire. The couple increased their sexual encounters to a frequency of about once every 6 weeks, and they were both satisfied with this result.

Gay Men, Gay Male Sexuality, and HIV

Since the beginning of the AIDS epidemic, research on gay male sexuality has focused almost exclusively upon HIV transmission and prevention, with less attention paid to gay male sexual dysfunction. Sandfort and de Keizer (2001), in a comprehensive review of research on gay sexuality, found that reports of erectile dysfunction (ED) were higher for gay men than for heterosexual men but that complaints about rapid ejaculation (RE) or delayed ejaculation (DE) were uncommon, as were reports of low sexual desire, except among HIV positive men.⁷ Bancroft, Carnes, Janssen, Goodrich, and Long (2005) found similar results, and Hart, Wolitsky, and Purcell (2003) also report high ED rates in gay men. These differences may reflect the specific common sexual behaviors of gay men. Gay men do not experience the pressure felt by heterosexual men to ejaculate during intercourse while “lasting” long enough to pleasure their partners, but they do feel pressure to “perform,” which may account for the high rates of reported ED.

Gay men are more sexual than women or heterosexual men, with all studies comparing them showing more frequent sex, more casual sex, and greater numbers of partners (Martin, 2006; Sandfort & de Keizer, 2001). Despite AIDS, sex is still a dominant force in the lives of gay men, providing social networks, affirmation of identity, and access to transcendent, spiritual experience (Martin, 2006). Therapists should expect that sex will be very important to most of their gay male clients and that clients will engage in a wide range of sexual encounters and behaviors. Moreover, nearly half of all male couples are nonmonogamous (LaSala, 2004; Parsons, Starks, DuBois, Grov, & Golub, 2011). The most common form of sexual openness, sometimes called “monogamish” relationships, are couples who regularly bring a third man into their sexual encounter, and often the couples who have this kind of sexual arrangement report the highest levels of relationship satisfaction (LaSala, 2004). BDSM, often called “leather sex,” has been an integral part of gay male sexuality for decades, with the terms “top” and “bottom,”

⁷HIV appears to lower testosterone, as do some of the medications used to treat it.

borrowed from BDSM, used by gay men to designate insertor versus insertee in oral and anal sex (Hart et al., 2003). Clinicians working with gay couples should expect many of them to be sexually nonmonogamous and be prepared to help the couple with problems that arise from this openness without judging the arrangement. It may be even be appropriate to question why a couple does *not* have an open relationship in cases of very discrepant interests or desire.

HIV remains a huge problem in the gay male community. Gay and bisexual men remain most affected in the United States, with 61% of all new seroconversions in 2009 (Centers for Disease Control and Prevention, 2011). "Barebacking"—anal sex without a condom—remains common, especially among younger men. Because prevention techniques developed in the 1980s appear to have reached the limit of their effectiveness, many now advocate a harm-reduction approach through techniques such as "serosorting," or encouraging men to bareback only with men of similar HIV status (Philip, Yu, Donnell, Vittinghoff, & Buchbinder, 2010).

Case 2: Using Harm Reduction with a Sexual Risk Taker

Toby, a 30-year-old HIV-negative man, entered therapy with concerns about his practice of barebacking with partners found on the Internet. Toby had never known anyone who died of AIDS, and although a friend of his had recently become HIV positive, the friend was on combination antiretroviral therapy with no apparent adverse side effects, and this probably muted Toby's concern about becoming infected. Toby did not want to be HIV positive, but he felt unwilling or unable to give up barebacking. He believed that barebacking increased his sexual currency, that it enabled him to have sex with men he deemed more attractive than himself, who he feared would not be interested in him if he insisted on safe sex. Because of the riskiness of Toby's behavior, the gay male therapist treating Toby decided on an initial harm-reduction approach rather than a deeper exploration of the self-esteem and body image issues that probably drove Toby's somewhat compulsive sexuality.

Toby was not confident that he would use condoms regularly. Although he readily agreed that he should, he was unsure of his ability to do so in the heat of a sexual encounter. The therapist suggested he try serosorting as an alternative. Toby felt more capable of using serosorting, but he needed to develop skills to accomplish this method of prevention. Toby felt unable to raise the topic of HIV status with men he encountered online for fear that he would be rejected. His therapist suggested that in order to develop the skill of asking about serostatus, Toby begin by asking about HIV status only with men to whom he was *not* attracted. Toby learned that although some men were offended by this, others responded well, and some were even relieved. After learning to ask the HIV status of men he did not desire, he was coached to do this with men to whom he was moderately attracted. After about 3 months he was able to ask all the men he flirted with online their HIV status, and he had sex only with men who identified as being HIV negative. Although the serosorting method is clearly not foolproof and relies upon the honesty of

partners, for Toby it was a step toward reducing the possibility of seroconverting.

The clinician in this case, the late Michael Shernoff, incorporated a “queer” perspective in his acceptance of frequent, casual sexual encounters with multiple partners and barebacking and in his practical, objective view of risky behavior. This allowed him to enthusiastically endorse a harm-reduction approach instead of labeling this man a “sex addict,” which many pathology-paradigm clinicians would have done.

Bisexuality

Within the LGBTQ community, as well as without, bisexuals have historically been either invisible, labeled “straight” or “gay” according to the gender of their current partners, or feared, mistrusted, and despised, although younger people are more accepting and more likely themselves to identify as bi- or pansexual. When homosexuality was more highly stigmatized, the use of the label became associated with gay people who couldn’t accept their homosexuality and were prone to desert their same-sex lovers for socially acceptable heterosexual relationships. In addition, lesbians have mistrusted bisexual women because they are seen as bringing sexually transmitted infections (STIs) into the women’s community (Nichols, 2006; van Rosmalen-Nooijens et al., 2008). Among heterosexuals, a study rating attitudes toward a multitude of stigmatized racial, social, religious, and sexual groups revealed that bisexual men and women were rated lower than all other groups except injecting drug users (Herek, 2002). The negative attitudes about bisexuality are probably related to widespread ignorance and misunderstanding. Many people simply do not believe bisexuality exists, including, in the recent past, some sex researchers.

There are substantial data that suggest that bisexual attraction, behavior, and identity are more common among women than men, including studies of physiological arousal (Chivers, Seto, & Blanchard, 2007; Cerny & Janssen, 2011) and survey data (Chandra et al., 2011). Three times more women identify as bisexual than lesbian, whereas among men slightly more identify as gay than bisexual, and same-sex sexual behavior appears to be increasing among young women but not young men (Gartrell, Bos, & Goldberg, 2012), although it is not known how these young women will eventually identify themselves. Many self-identified bisexuals are also transgender, “kinky,” or polyamorous. The clinician needs to pay close attention to what each client means by self-identifying as bisexual and to be mindful of the double stigma attached to the label that may leave the person feeling isolated and alone even within the LGBTQ community.

Special Problems of Gender-Variant Youth

It is beyond the scope of this chapter to fully discuss the highly controversial issues of transgender clients, but it is important to touch on the problems faced by gender-variant youth, as they are becoming the fastest growing and

most visible members of the LGBTQ community. LGBTQ teens have higher rates of abuse and distress than other adolescents, and, within this group, distress is highest among gender-variant youth (Skidmore, Linsenmeier, & Bailey, 2006), because they are more visible than their gender-conforming peers. They get less support from parents (LaSala, 2010), and they are often the targets of bullying in school.

Because they suffer such distress, gender-variant young people are more likely than other queer youths to come for treatment. With treatment aimed at getting these young people to conform to traditional gender roles discredited, queer clinicians are developing alternative models of treatment that involve affirming and validating the child's nonconformity, encouraging parental support, and finding ways to protect children from peer abuse.

Like gay, lesbian, and bisexual youth, transgender people are "coming out" at earlier ages, and clinicians will increasingly see younger teens and even preteens who identify this way or who identify as "genderqueer" or "gender fluid." Some young people will need help sorting out their identity, and clinicians will increasingly be asked by parents to assess whether their children are "really" transgender, an assessment that is by definition imprecise because so little is known of the developmental trajectories of gender-variant children. Many clinicians will not be comfortable assuming this responsibility, and they should be able to refer to colleagues who will. When the adolescent already is certain of his or her gender identity, different issues come into play. The treatment protocols for young gender-variant people approved by WPATH and the U.S. Endocrine Society (Hembree et al., 2009) call for administering "puberty blocking" hormones early in the process, for social transition in the early teens, for cross-gender hormone treatment as young as 16, and for GRS as early as 18. Outcome research on these young people has shown that they do not regret their early transition and that they are as psychologically well adjusted as their nontransgender peers (Cohen-Kettenis et al., 2008). Because puberty blockers prevent the emergence of body changes associated with biological gender, young people given growth-blocking hormones at early stages of puberty never develop the physical characteristics that might "give them away" in their affirmed gender. Administered appropriately, growth-blocking hormones, followed 2 or more years later by cross-gender hormones, can make the difference between a transgender person who can "pass" and one who will not. Because the blockers are reversible, their use provides a "time-out" for the teen to explore gender issues and clarify identity. From a queer perspective, "the suspension of puberty is not only not unethical: if it is likely to improve the child's quality of life or even save his or her life, then it is indeed unethical to defer treatment" (Giordano, 2008, p. 580). Norman Spack and his colleagues, who released data on nearly 100 gender-variant youth using the preceding protocol in 2012, obtained the same result as Cohen-Kettenis and colleagues. Spack et al. (2012) noted that their sample contained a large percentage of young people with emotional disturbances such as depression, suicidality, and self-injurious behavior and that treatment

with puberty-blocking and cross-gender hormones caused most of the disturbance to abate. Our experience at IPG parallels these findings. Many of us are used to treating older transgender people who transition after decades of hiding and whose lives are often shattered by transition. By contrast, it is notable that many gender-variant young people are free of mental illness or emotional disturbance once they are affirmed and supported and receive proper treatment.

Supported by parents and advocacy organizations such as TransYouth-FamilyAllies (TYFA), some gender-variant children are socially transitioning as early as 5 or 6 (Ehrensaft, 2011), although the WPATH Standards of Care recommend caution with such early transition because longitudinal studies show that less than 50% of gender-variant children persist in a transgender identity into adulthood (Wallien & Cohen-Kettenis, 2008). How does a therapist respond to a 5-year-old natal boy who has insisted since his first words that he is a girl and whose parents want a social transition? Although we know that not all such children persist in their gender dysphoria, we are currently unable to predict which of them will. At IPG we are more cautious about prepubescent gender-variant children. When possible, we help parents structure an environment in which the child's nonconforming expression is permitted, validated, and supported, and where the child is not stigmatized in his or her school and community. Young natal boys have been more common in our practice than very young girls, possibly because gender-role norms for young males are so rigid and so viciously punished when violated. With these young boys we have advocated and educated the school system, guided the parents to activities in which nonconformity is permitted, for example, dance, and referred to groups for young gender-nonconforming children to decrease the child's isolation. But as of this writing we have had one young client, a 6-year-old natal boy, who was so severely dysphoric about his assigned gender that we supported the parents in a full social transition. At this juncture, 2 years after transition, the child seems to be doing well living as a girl in her school and community. However, parents and therapist give frequent reminders to the child that her identity can be fluid if she chooses.

Polyamory: The New Critique of Monogamy

Space does not permit more than a passing mention of polyamory and other forms of open relationships. As noted, open relationships are common among gay men and polyamorous ones increasingly common among lesbian and bisexual women (Munson & Stelbourn, 1999). Consensual nonmonogamy (as distinct from "cheating") is not new, even among heterosexuals. In the United States, nonmonogamy movements have been popular at several different points over the last century or two, with "swinging" the most prominent in recent decades. Polyamory, the practice of having multiple sexual and romantic relationships concurrently, is a newer iteration. In recent years, nonmonogamy as a valid lifestyle has received public visibility and curiosity, if

not full acceptance. A number of books aimed at sophisticated general audiences have increased awareness of open relationships (Taormino, 2008; Ryan & Jetha, 2010), including a best-selling memoir by a polyamorous suburban wife and mother (Block, 2009). Therapists working with polyamorous people become accustomed to doing relationship counseling with three or more people in the room, and accepting therapists might even occasionally suggest some form of open relationship to a receptive monogamous couple searching to revive a boring sex life.

Case 3: Two "Lifestyle" Couples Attempt Polyamory

Roy and Connie entered treatment together as a late-middle-aged couple with a fundamentally sound 30-year marriage, the last 20 of which had been spent as "lifestylers"—swingers. Swinging as it is practiced today often goes beyond purely casual encounters; both Roy and Connie had occasionally had ongoing outside partners with whom they developed somewhat intimate, as well as sexual, relationships. Recently, Roy had ended such a liaison and, as often happens in open relationships, the balance shifted in the marriage and problems emerged that needed tending, problems not directly related to sex or swinging. The couple saw me regularly for a few months, and we "fine-tuned" the relationship, helping Connie become more assertive, Roy more attentive, and so on. In addition, I helped them "come out" to their grown children, as they had grown tired of secrecy. Although the couple feared a negative reaction, after some initial shock the children decided their parents' lifestyle was "cool." Then the couple became involved in their first clearly polyamorous network. They became intensely intimate, sexually and in other ways, with another swinging couple, Adelle and Jason. When some problems of insecurity and jealousy emerged, they sought my help. Both couples had had previous experience with more traditional therapists who saw their nonmonogamy as an escape from intimacy, and so they were grateful when I assured them that I would work toward their collective goal of remaining together as a foursome. Over a period of 6 months I saw them in various combinations and permutations in what has been challenging but fascinating work. Much of my work involved guiding them to make their expectations explicit, helping them set boundaries, rules, and guidelines for interactions, and avoiding triangulation or hidden alliances. We established ways for the marital relationships to stay primary, such as reserving certain times, places, and activities as "special," not to be shared with the other couple. At this writing the two couples remain a happy foursome. Although I cannot predict how long the polyamorous relationship will last, I have seen relationships like this last for many years. Far from using outside partners to replace sex in the primary relationship, many open couples maintain exceptionally good sex with each other even after decades together. Roy and Connie and Adelle and Jason, married two and three decades respectively, reported frequent and hot sex in their marriages throughout treatment, and both couples asserted that the "heat"

had never left their marriages. My queer perspective with this case is obvious: I am enthusiastic about nonmonogamy as an option and knowledgeable about many of the common issues encountered when negotiating such alternative relationships.

CONCLUSIONS

Good clinical work with LGBTQ minorities involves more than acceptance of homosexuality. To be effective, the therapist must discard the traditional view that variations in sexual attractions and behavior and gender expression are symptoms of psychiatric disorder, suboptimal adjustment, or biological mistakes. This must be replaced by the perspective that variance is normal and adaptive and that “all sex and gender variance is innocent until proven guilty.” The sex therapist adopting a “normal variance” paradigm will work more skillfully with their LGBTQ clients and understand their special needs. Beyond this, therapists can learn from their LGBTQ clients: about alternative forms of relationships and family, about the range of gender expression, about issues that are universal to all couples versus those related to gender. The queer theory paradigm promotes good practice and the genuine celebration of diversity.

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