



INSTITUTE FOR
PERSONAL
GROWTH

Margaret Nichols, Ph.D.

Director

***Doing Sex Therapy with Lesbians: Bending
a Heterosexual Paradigm to Fit Gay
Lifestyle***

One of the important accomplishments of the women's movement in the last fifteen years has been the uncovering of aspects of female sexuality previously never discussed publicly. Feminists have been at the forefront of bringing a host of sexual issues out of the closet: abortion, rape, incest, clitoral orgasms, and lesbianism. Ironically, we have also occasionally helped keep an issue hidden. Through our own fear, embarrassment, and stereotypes, we have kept the problem of lesbian sexual dysfunction under wraps. Nancy Todor, in her article "Sexual Problems of Lesbians," writes that no one took her seriously when she was working on the subject: Lesbians themselves refused to acknowledge that sexual problems exist for our community.¹ I myself have also been criticized by other lesbians for discussing or writing about lesbian sexual dysfunction. Within the women's community, there seems to be great resistance to the concept of defining any aspect of lesbian sexual practice as a problem. As witness to that, I note that since my article on "The Treatment of Inhibited Sexual Desire" in 1982 there have been only a few published articles on lesbian sexual difficulties until JoAnn Loulan's *Lesbian Sex*.² But the silence and taboos within the lesbian community regarding lesbian sexuality and lesbian sexual problems are not only manifestations of puritanism or fanaticism. There are some good reasons to be cautious about defining, explaining, or treating lesbian sexual dysfunction. Historically, female sexuality has been defined by male standards and heterosexual norms and has thus been a source of oppression rather than help. This oppression has in fact sometimes taken the form of defining our sexual problems for us, as when, in the 1800s, the presence of sexual passion or masturbation in women was defined as a problem. More recently, the absence of a vaginal orgasm (or more recently yet, a G-spot orgasm) was defined as a problem. We do indeed need to be exceedingly careful of who defines our dysfunction for what reasons and by what criterion, lest that definition becomes a judgment levied for purposes of social control. Thus a thoughtful and politically sensitive sex therapist must consider labels of dysfunction, malfunction, or illness carefully.

To complicate matters, we also know that female sexuality, whether for environmental or biologic reasons, appears to take different forms from male sexuality, and that lesbian sexuality, representing female-female pairings, shows some unique manifestations. For example, Lillian Faderman, in her book on "romantic friendships" between women through the nineteenth century, emphatically demonstrated the existence of lesbian marriages completely devoid of genital sexuality.* Philip Blumstein and Pepper Schwartz found lesbian couples in the 1970s and 80s to have less genital sex than any other form of pairing.

From the point of view of a sex therapist, what does one make of this? Does this mean that inhibited sexual desire is endemic to the lesbian community? Or does it mean, as C. A. Tripp has suggested, that it is normative behavior for a lesbian couple to cease genital sexual activity after a few years?" It is important that we clear our minds of heterosexist/male models as we proceed in defining lesbian sexuality and dysfunction. Yet to do this leaves us essentially without adequate models; we must make our own.

Let me give an example: a lesbian couple, together for twenty-two years, whom I saw for sex therapy. The initial complaint was that all sexual activity between them had ceased for the last year and had been infrequent for many years previously. Upon detailed questioning, the problem became defined. Betty, named by both women as the less sexual of the two, enjoyed nongenital sexual activity and was quite happy to engage in sensual activity as well as to make love genitally to Agnes, her partner; however, she rarely desired to have Agnes make love genitally to her.

That is, she rarely desired or required that she herself have an orgasm as part of lovemaking, although she was perfectly happy to accommodate Agnes in that regard. Agnes, however, could not accept this. Her definition of sex included orgasm, and by this definition, Betty rarely wanted sex. Over the years, Agnes had stopped making overtures to Betty because it seemed that Betty didn't want sex, that is, the entity defined as an event in which both women tried for and achieved orgasms. When Agnes and Betty were helped to accept their differences, they were able to re-label sex as an event during which Agnes would probably strive to reach orgasm and Betty probably would not. Their sex life promptly began to thrive. Unfortunately, in the process of developing new models of sexuality we cannot rely much upon the mainstream field of sex therapy.

Although the medical terminology used within the sex therapy field creates an aura of objectivity, as if the entities described as "dysfunctions" were real illnesses with material causes, in fact everything about sex therapy is quite subjective and biased. Consider, for example, the designation of "premature ejaculation" or "inhibited sexual desire," implying knowledge that the individual's sexual desire is really present but blocked or somehow repressed.

The sex therapy field is not only subjective, but it is also biased heterosexually. Heterosexual sex and relationships are not so much taken as the norm as they are unconsciously assumed to be the only kind of sex and relationships to exist. For example, the labeling of sexual dysfunction revolves around heterosexual intercourse. Many dysfunctions seem to have, as their connecting characteristic, the quality that they make intercourse difficult if not impossible: that is, premature ejaculation (defined by William Masters and Virginia Johnson as the inability to sustain erection without ejaculation within the vagina for a certain length of time) or erectile dysfunction in males, or vaginismus or dyspareunia (painful intercourse) in females' Gay or lesbian lovemaking techniques are ignored within the framework of the field. Thus difficulties with anal sex are nowhere defined or discussed within the mainstream literature, despite the fact that they are probably the most common presenting problems shown by gay males in sex therapy.

Sexual techniques such as S/M, the use of rubber or leather, or involvement with urine or feces, commonly seen as sexual enhancers by gay men, are labeled "paraphilias" by traditional sex therapists. Oral sex problems, among the most common complaints of lesbians seeking sex therapy, are absent from the literature on dysfunction, as are problems concomitant with the "your turn, my turn" sex that is perhaps more typical of lesbians than any other group. Similarly, the use of dildos and vibrators, an integral part of lovemaking for at least a minority of lesbians, is rarely discussed as anything more than an occasional sexual enhancer.

I am going to suggest some new models for sex therapy with lesbians. My approach will be best understood by those who have at least some familiarity with the work of Masters and Johnson and Helen Singer Kaplan,* I would strongly recommend reading these experts and obtaining supervision from an experienced sex therapist before attempting independent sex therapy. My therapeutic approaches are based primarily on my experiences with white middle- and working-class East Coast lesbians from the mid-seventies until the present. Recognizing this time frame is important, because lesbian sexuality is changing. We talk now at conferences about redefining the clitoris or about "safe sex" techniques for lesbians." We are proud to see ourselves as sexual beings at the same time that we are expanding our sexual techniques and practices. Thus sexual problems and solutions defined in the eighties may not be relevant by 1990.

The Role of the Therapist in Sex Therapy

Typically, the role of the therapist in sex therapy has been to be active and directive but a bit authoritarian and distant. One sex therapist I know even advocates wearing a white lab coat if in medical school or hospital settings, and many routinely call their customers "patients" and require that customers call them "doctor." These distancing and hierarchy techniques have been recommended to enhance the authority of the therapist and increase the likelihood that therapeutic directives will be followed. Most lesbian therapists working within the lesbian community will find this authoritarian stance impractical, even if it does not conflict with their own values. I have found that an active and directive stance is essential within sex therapy: A good deal of sex therapy is behavioral, utilizing homework assignments and so on, and there is little that would require a nondirective stance such as analysis of transference. On the other hand, I have found it impossible to be distant.

Lesbian communities tend to be so incestuous and enmeshed that I, like most lesbian therapists, find boundary-setting to be difficult. Furthermore, an authoritarian stance would turn off most of my clients, who value egalitarianism and distrust hierarchy, even in a therapeutic relationship. Few of my clients would be willing to call me "Dr. Nichols," even if I wanted them to.

Most therapists function as role models for their clients at least some of the time. I find this is particularly true within the lesbian community. Lesbians, like other members of oppressed minorities, hunger for positive images and models; therapists become prime objects for this appetite. Indeed, the combination of the interweaving of most lesbian communities and this fierce need for role models makes the open lesbian therapist both more accessible and visible (and thus more scrutinized) than most therapists, and also more revered. I find myself considered much more than a therapist: a combination shaman/wise woman/witch/bad mother/good mother. It is a peculiar and rarely discussed position to be in, yet it has particular importance for lesbian sex therapists. Given the generally sex-negative attitudes women hold, and given the sexual rigidity of the lesbian community as evidenced by the rhetoric of "politically correct sex," lesbian sex therapists need to model sex-positive attitudes. I have found this often means giving explicit messages about the inappropriateness of the concept of political correctness as applied to personal sexuality. It also may mean giving permission to consider sex as not very important, as well as giving permission to enjoy a wide variety of sexual styles. It means succumbing neither to the stereotypes that heterosexuals have had of our sexuality nor to the stereotypes that we have perpetuated about ourselves. Pat Califia illustrated- these extremes articulately when she once joked, "If I have a sexual problem and I go to a straight health care provider, he will treat me 'knowing' that as a lesbian I always use a dildo, always have one-night stands, always engage in unusual sexual practices, and always am promiscuous. If I go to a lesbian health care provider, she will treat me 'knowing' that as a lesbian I never use a dildo, never have one-night stands, never engage in unusual sexual practices, and never am promiscuous."

Common Sexual Problems Found in Lesbian Populations

Within the mainstream field of sex therapy, most practitioners have categorized sexual functioning/dysfunction by using either the four-stage model of the sexual response cycle developed by Masters and Johnson or Kaplan's three-stage model. While in the past I also have attempted to conceptualize gay and lesbian problems within the frame- work of these models and found Kaplan's model to be the best because it is more encompassing, I now feel that there are so many sexual problems

found among lesbians that really don't fit into either of these essentially biology-based schemas that I don't attempt to categorize lesbian dysfunction into response cycle patterns. One of the newer ways of looking at sexual dysfunction in general is through the technique of script analysis. Script analysis sees dysfunction in individuals or couples as primarily the result of faulty sequences of behavior—scripts—that individuals or couples play out repetitively and usually unconsciously. Script analysis with heterosexual couples often becomes analysis of how men and women in couples play out sexist roles, and this is not applicable to lesbian couples. The concept itself, however, of looking at dysfunctional sequences of behavior is much more productive in categorizing and assessing lesbian dysfunction than the four-stage or three-stage models. For example, the case of Betty and Agnes could not easily be defined by either Masters and Johnson or Kaplan.

Although at first this couple presented as a case of inhibited sexual desire, this designation (from Kaplan's schema) is inadequate to describe these women's problems. On the other hand, their problems could easily be characterized by clarifying the two conflicting scripts that resulted in a repetitive "couple script" that was so maladaptive that eventually the couple ceased playing the game at all.

Lesbians do sometimes suffer from some of the more well-known and easily labeled female sexual dysfunctions, including primary anorgasmia (the complete inability to experience orgasm). I have found lesbians to be less likely to manifest primary anorgasmia and more likely to exhibit a form of secondary anorgasmia (the ability to orgasm through self-stimulation but not through lovemaking with another person). Therapists sometimes see general arousal deficits, but I have never seen a case of vaginismus or dyspareunia. I suspect that this is simply because if penetration is problematic or uncomfortable for a lesbian she simply eliminates penetration from her sexual repertoire.

Low desire, inhibited sexual desire, and desire discrepancy problems in couples are probably the most common presenting problems of lesbians who seek sex therapy." One encounters individual lesbians who complain of lack of interest in sex. Far more common is that general sexual uninterest or sexual inhibitions surface in ongoing relationships only after the limerance phase of the relationship has passed.

As Blumstein and Schwartz and Trip have observed, it is common to find extraordinarily low levels of genital sexual contact among lesbians in couple relationships, and even to find relationships in which sexual contact has completely ceased despite an otherwise apparently harmonious relationship."

As clinicians, do we counsel lesbians to accept this situation and reject as patriarchal their internalized standards of genital sexuality? Or do we assume that low levels of sexual contact are "abnormal"? I have tended to take a perhaps traditional view: I do not meddle in relationships where neither partner has complained, but if there are complaints of low desire or frequency, I assume that this situation is dysfunctional and attempt treatment. I contrast this, for example, with my approach if a lesbian complains of a lack of multiple orgasms. In such a case I would point out that only 18 percent of women experience multiple orgasms, and would counsel the individual to consider changing her standards of sexuality.

When confronted with low sexual frequency in lesbian couples, I generally attempt differential diagnosis with regard to the following possible diagnoses:

sexual inhibition problems in one member of the partnership, including history of

assault or incest
extraordinarily high sexual desire on the part of one partner
relationship problems surfacing via the sexual relationship
sexual script problems, for example, the case presented earlier
sexual frequency problems that are the secondary result of another sexual
problem such as an oral sex phobia
sexual frequency problems as a result of simple boredom and the need for sexual
enhancement in a long-term relationship

Other sexual problems experienced by lesbians do not fit easily within a four-stage or three-stage framework. For example, aversion to oral sex is an extremely common complaint. Most typically, a couple will seek help because one member has this aversion, and the partner feels strongly that oral sex must be a part of lovemaking. Sex therapists are unlikely to encounter couples in which both partners are aversive, or both agree to exclude cunnilingus from their sexual repertoire. Sexual difficulty experienced by some lesbians in the past was common enough so that the subculture developed a name for it: being a "stone butch." Until the advent of the lesbian-feminist movement, and even now among working-class and third-world lesbian communities, it was customary for lesbians to choose either a male or female role in relationships. Some of the women who acted out the male role denied their femaleness to the extent that they would not allow their partners to touch or make love to their bodies. When I practiced in a working-class, poor community farther from a large urban setting, a number of women who fit this description came for treatment, usually because of complaints from their lovers. It is becoming less and less common a phenomenon.

This does not mean, however, that so-called role-playing or expectations about roles never affect lesbian sexuality. One sees couples in which one or both partners feel constrained always to be either the aggressor or the recipient of sexual advances. One woman, Enid, sought therapy because she was unable to tolerate sexually assertive partners and began to see this as a problem in that in all her relationships lovers complained of this rigidity. In another case, Lisa was unhappy because her lover, Andrea, refused ever to be sexually assertive; Lisa wanted to "be seduced" at least occasionally. It is worth noting, by the way, that the roles lesbians fall into sexually do not necessarily correlate with either stereotypic appearance or interest; that is, the partner with the short hair and work shirts, the partner who loves to play softball, may also be the partner who cannot be or prefers not to be sexually aggressive.

The impact of lesbian-feminism has produced another almost opposite kind of sexual role problem. That is, the ethic of egalitarianism when translated to politically correct sex has meant that many lesbians feel that it is unacceptable for partners to have different sexual tastes, especially if these tastes appear to correspond to what are thought of as male-female differences. For example, Barbara and Susan complained of low sexual frequency in their relationship. Upon further analysis, it appeared that the couple's sexual disinterest stemmed from Barbara's preferring to be the more active partner in sexual encounters and Susan's preference to be less active, more the recipient. Neither partner, however, felt that this was "okay"; both feared that this differentiation might lead to role-playing or power differentials in nonsexual aspects of the partnership. Consequently, both constrained their sexual impulses, and sex had become ritualistic and stultifying. It is partly in recognition of this diversity of sexual proclivity that the lesbian butch-femme liberation movement has arisen.

These problems are examples of script problems: sexual difficulties that arise from differing, conflictual, or covert sets of expectations about how sex should be among partners. Although script problems can exist in any type of couple, there are some types of script problems—over avoidance of role-playing, for example—that seem largely idiosyncratic to the lesbian community. Some script problems have to do with differences over the newly emerging S/M, or sadomasochism, movement in the lesbian community, or differences involving the issue of nonmonogamy. One lesbian in a relationship may have strong S/M proclivities while her partner's sexual script calls for sex always to be gentle. In another case, one woman may find the idea of nonmonogamous relationships to be repugnant, while the other cannot function, sexually or otherwise, in a relationship unless it is monogamous. Lesbian S/M and lesbian nonmonogamy are worth discussing a bit further, for not all the sexual problems attendant to these two issues are script, or expectation, problems. Sadomasochistic sexual practices, although undoubtedly not entirely new to all lesbians, are newly defended by a community that in the past was not only relatively sexually repressed, but which also severely judged sexuality on the basis of political correctness. Because the lesbian community has been so repressed sexually, with sexual techniques confined to those the S/M advocates call "vanilla sex," the S/M movement caught on like wildfire.

In the early 1980s no lesbian conference was complete without a S/M workshop, no rap group survived without discussing S/M, no couple could not at least consider S/M or its impact on the community. Although the overall repercussions of this movement have been productive and beneficial to lesbians, some problems do exist. Not all people are stable enough to use a sexual enhancement tool like S/M in a healthy way: Clinically, lesbian therapists have been seeing some women who really hurt each other through S/M practices, and some women who become compulsively addicted to S/M and push themselves on to potentially self-destructive levels of pain.

It might be said that the S/M controversy took the place in the early 1980s that in the seventies had been filled by the nonmonogamy controversy. Nonmonogamy is no longer so much debated among lesbians. Many, perhaps most, lesbians aspire to a monogamous ideal in relationships, while a significant minority espouse an ethic of nonmonogamy. (This is very different from what one finds among heterosexuals, where few people would view nonmonogamy as a principled decision.) Most lesbians who attempt to succeed in committed relationships at the same time as they practice nonmonogamy do so in a way almost guaranteed to destroy the primary relationship. Lesbians, unlike many heterosexuals and unlike gay men, have affairs rather than casual sex when they are nonmonogamous." Indeed, they are likely to have these affairs with close friends who are intimately entwined in their lives and the lives of their committed partners, and they are usually open about these affairs, not just to their partners but often to the whole community. These situations can be disastrous. When lesbian couples desire nonmonogamy, I try to help them develop clear rules and guidelines to protect the primary relationship and minimize the potentially destructive jealousy such affairs can generate.

The final set of problems one encounters in sex therapy with lesbians is the most difficult to describe and is exemplified by the example I cited earlier, of Betty and Agnes. Given the sex-negative way in which most of us are raised, given our difficulty communicating with partners over sex, it is not unusual that we suffer in our relationships from clashes between individual sexual scripts where those scripts are private, perhaps ill-defined even to the individual, and rarely or never discussed between the partners.

The Assessment of Sex Therapy Problems

The key in assessment of sex therapy problems is specificity. Even when lesbian couples come to treatment asking for help with sexual issues (and most do not, but will instead present with more general relationship problems), they really are not actually prepared to talk about sex.

It is critical that the clinician be calm, matter-of-fact, and explicit about sex, even in the face of giggles, shuffling feet, red faces, and averted eyes. When couples come to me for relationship counseling, I ask questions, both in a personal interview and on a written questionnaire, about frequency and quality of sexual interaction and about the existence of any sexual problems. If sexual problems emerge, I can then discuss with the couple their interest in working on these problems and when. Many lesbian couples who experience sexual difficulties as only one of a number of relationship problems prefer to wait until later in treatment to deal with these issues, and often it is just as well to wait until other conflicts have been resolved.

When couples come to treatment asking for sex therapy, or when a couple with other relationship issues decides it is time to deal with their sexual trouble, it is best to get as much specific detail about the situation as quickly as possible. In the first interview, I seek the following information:

What is the problem in exact terms? Not "we don't have sex very often," but "we only have sex once a month and I would like it twice a week"; not "our sex life isn't as exciting as I would like it to be," but "I would like her to go down on me and she won't."

What is the history of this problem? When did it start and what were the circumstances; has it been chronic, periodic, acute? Most critically, is this a problem either woman has experienced before, either alone or with other partners?

What other attempts have the couple made to solve this problem? How did they work? This tells me what interventions to avoid as well as giving me some idea of what behavior has maintained the problem, because attempts to solve a problem often turn out to worsen the situation.

Along the same lines, what are the individuals' own assessments of the problem? Often couples have a very good idea of how problems started, what caused them. They know how they got into the mess they are in, they just don't know how to get out. Even if I think the assessments are out of line, this question at least gives me information about the belief systems I need to cope with in devising my strategies. If a client feels her problems are the result of early childhood conflicts and I privately disagree, I know I have to frame my intervention in terms of solving childhood conflicts in order to make it acceptable to the client.

Why did the couple seek help now, as opposed to last week, last month, last year? This is a crucial question, because most couples will struggle along with sexual conflicts for long periods of time without seeking therapy. The answer can give some good prognostic information. For example, when the couple has come because one partner has finally threatened to leave unless their sex life improves dramatically, therapy will be more difficult than if, as one couple said to me recently, they are coming to therapy because the rest of the relationship was going so smoothly that both partners felt they could look non-defensively at sexual problems that had existed for several years.

I try to get in the first session a detailed description of the last time the couple made love. When was it, what were the circumstances, who approached

whom, how did the situation progress, how did both partners feel? If it seems relevant and is not obvious from the partners' narrative, I will ask specific questions about sexual techniques used. In gathering this information, as with other information obtained from the couple, it is important to note the degree of discrepancy in both women's reports of the same situations.

After my first joint assessment session, I typically schedule an individual session with each partner. There are three purposes for this:

1.) I obtain a general impression of each woman as an individual, separate from her coupled state; 2.) I cross-check information given in the presence of the partner to see how synchronous or discrepant data are when given alone or with the partner. I also give each partner, alone, the opportunity to say anything that is relevant that she might not want to say in front of her partner, and I do this primarily to find out if there are any secrets, such as an affair, that might affect the course of therapy; 3.) I gather a detailed individual sexual history. Included in this history are data about earliest sexual experience, both lesbian and heterosexual; sexual abuse or trauma; masturbation and fantasy experiences; and sex-positive or sex-negative messages received in childhood and adolescence. I pay particular attention to heterosexual experiences and to the coming-out history. I have found that early negative heterosexual experiences (very common among lesbians who often had sex with men in order to "fake" heterosexuality, rather than from desire) and a difficult and conflict-laden history of coming to terms with lesbianism affect later sexuality, years after both types of events have been cognitively and intellectually understood and processed.

By this time, I have a reasonable assessment of the problem and have devised intervention strategies. In formulating my view, I think in terms of the cause of the problem, the factors that maintain the conflict, and intervention techniques, but do not assume that the last are necessarily related to the first or even necessarily to the second.

Some of the questions that may serve as guidelines for me are: Is this primarily a couple problem or a difficulty caused by one member of the partnership? If it is a couple problem, how much is the sexual problem separate from other relationship issues and how much is it a symptomatic result of other problems? To what extent can the sexual problem be approached without addressing other individual or relationship issues? To what extent can the sexual problem be solved behaviorally, without addressing root causes at all? For example, Rita and Mary asked for sex therapy because they had had sex together only twice in the past year. During the assessment process, it was learned that Mary had never had sexual difficulties in prior relationships, but that Rita had always found herself unable to experience desire after about six months in a relationship, and that the thought of being the sexual aggressor in an encounter was almost repulsive to her. Moreover, she had a history of sexual molestation as a child, extremely sex-negative early messages, and a very difficult time accepting her lesbianism. I decided that the problem really resided in Rita, not Mary, but that Mary was needed almost as a sexual surrogate for sex therapy. Rita herself viewed her sexual issues as resulting from her early childhood molestation. I decided she was probably correct, but that she was not emotionally prepared to unearth and discuss these experiences. Moreover, Mary would probably not be willing to wait a long time for their sex life to improve. Therefore, I opted for a strategy that included a couple of sessions alone with Rita so that she could superficially discuss her early experiences and then a course of fairly traditional, behaviorally oriented sensate focus experiences.

One final tool I use for assessment, in fact, is the sensate focus exercises themselves. Often by the second conjoint session, I give a homework assignment of sensate focus (described later) to see how the couple reacts. Their reaction in the session, but especially how they carry out or fail to carry out the exercise, gives me a final, very complete picture of the extent and severity of their problems.

So far, I have been talking exclusively of couples, because by far most lesbians request therapy for sexual difficulties in the context of a couple relationship. Generally I will not attempt therapy only with one member of a couple, unless after assessment I determine that individual therapy is the preferred mode. If asked, I will treat single lesbians for sexual dysfunction. This is often more difficult because many problems simply cannot be treated in the absence of a partner with whom to try out new sexual ways of being, homework exercises, and so on. To date, I have not considered the use of sexual surrogates with lesbians.

The Causes of Sexual Dysfunction in Lesbians

In general, many of the same root forces that shape sexual dysfunction among heterosexual women and heterosexual and gay men operate for lesbians as well: performance anxiety, anxiety caused by guilt about sex, depression, classical conditioning paradigms, relationship issues, and so on. Medical conditions are perhaps even more rare as the causes of lesbian sexual problems than is true for heterosexual women, because with heterosexual women these medical causes are usually tied to dyspareunia, a complaint rare among gay women.

Some causal factors of sexual unhappiness are special to the lesbian population. Virtually all lesbians have had heterosexual experience" and much of this has been quite negative sexual experience associated with no pleasure, with inauthenticity, even with a sense of being exploited. This early conditioning can remain as part of a lesbian's sexual response—the concepts of functional autonomy and classical conditioning are quite important here—long after she relates only to women and cognitively views sex quite positively. Early anti-gay attitudes, similarly, can linger long after a gay woman has come out. Further, many lesbians denied their sexual orientation to themselves for extended periods of time by repressing their sexual (but not emotional) attraction to women. Again, the tendency to repress sexual desire may remain despite a heartfelt wish to be sexually active. Finally, the lesbian may learn to reject one whole set of sexual standards—that of the heterosexual society she grew up in—only to assimilate a new set of sexual imperatives from the lesbian community. She may no longer believe her sexual fantasies about women are "bad"; now she may feel that the sexual fantasies she has about men are politically incorrect, or at least dissonant with her gay identity.

Therapeutic Tools

For a complete discussion of sex therapy techniques, I refer the reader to existing texts in the field, especially Masters and Johnson, Kaplan, and Leiblum and Pervin." Briefly, here are some principles I have found useful:

When possible, I go from the simple to the complex, rather than the other way around. In other words, I will often try a simple intervention—information-giving or support and acceptance, for example—before I assume that more complex maneuvers are necessary. In particular, I will frequently use behavioral techniques even if I suspect a behavioral approach will be too simple to work.

Along the same lines, I frequently use sensate focus as a partly diagnostic, partly therapeutic technique. I employ the Masters and Johnson technique that uses a series of gradually more sexual pleasuring exercises. I will frame the sensate focus homework in a win/win way: "Either you will find this a positive experience, and that will be helpful, or else you will experience negative thoughts and attitudes and that will help us pinpoint your problem."

I try to encourage a ban on sex within the relationship for the duration of therapy, and especially a ban on outside affairs for the time of therapy, but, as discussed earlier, I do not do this in an authoritarian way. I often say something like, "Of course, I can't tell you what to do, but. . ." and then elaborate in a straightforward manner all the reasons why the bans would be productive and advisable. Clients usually get the point. I also, like other sex therapists, rely heavily upon homework assignments and take a similar stance regarding homework assignments as I do with bans.

Many of my techniques are behavioral and include systematic desensitization procedures (for example, I find in vivo desensitization to be the therapy of choice for lesbians with oral sex phobias), sensate focus, guided imagery, and fantasy. At times I also use hypnosis for its value with imagery, fantasy, and visualization rather than for purposes of direct suggestion.

I will see couples or individuals for sex therapy, although it is usually preferable to see couples. Couple counseling is a useful way to approach sex therapy because, first, many sexual problems really are or have become couple rather than individual problems. Second, even when one determines that a sexual problem belongs to an individual rather than to the couple, the partner can often be used as a sexual surrogate, or, in other words, an undemanding and sensitive partner who will help her partner carry out behavioral exercises.

It is in most instances more difficult to treat individuals who do not have a partner, even if the sexual problem really does belong to them. There are some behavioral methods that simply don't work without a partner. I rely upon guided imagery and fantasy exercises with the understanding that the client may need eventually to come back for additional help when coupled.

To help lesbians I have occasionally used groups specifically designed to deal with sexual problems. Although it is difficult to assemble such a group, I find these sex groups to be incredibly powerful tools for women who are inhibited, experience low desire, or have orgasm problems. Lonnie Garfield Barbach's books are indispensable for this type of group work."

Bibliotherapy is an invaluable tool, particularly when dealing with sexual problems that are rooted in homophobia. In a sense, bibliotherapy is an alternative to a group and provides much the same thing: not simply information, but validation from other women. In addition, erotic books can be useful in therapy as methods of helping women become more sexual and to discover previously unknown aspects of their sexuality.

Enhancement of Sexuality

Just as the line between dysfunction and preference is blurred in the area of sexuality, so is the line between sex therapy and sexual enhancement. I believe that not only is it a legitimate function for sex therapists to serve as sexual enhancers for lesbians, particularly those in long-term relationships, but I also think it is a necessary function. If, as I believe, problems with sexuality are a leading cause of deterioration of lesbian relationships, it is critical that as therapists we play a role helping gay

women renew and revive flagging sexuality.

It seems clear at this point, both from the work of sex researchers and from common experience, that few couples sustain the height of sexual passion that is the hallmark of the initial limerance phase of a relationship." It may be one of the great paradoxes of relationships, in fact, that the more one loves and is comfortable with one's partner, the less automatic and jolting is sexual desire. Gay men compensate for this loss of lust in the primary relationship by tricking: casual or anonymous sex with outside partners that serves as a sexual outlet but theoretically does not threaten the committed relationship. Lesbians, more than any other kind of couple, seem to suffer from the loss of limerance: Their frequency of sex becomes lowest of all couples, and if they do turn to outside sex, it is usually an affair rather than tricking, and usually that can have negative effects upon the primary relationship. What are we to do about this situation? It appears to me that lesbian couples need to turn more energy to enhancing and revitalizing sex within the primary relationship.

Of course an alternative to this is for lesbians to learn to trick. This seems in theory a fine idea to me, but I think it may take several new generations of lesbians to make it work. I know few women who really are turned on by casual sex, fewer still who can keep the sexual relationship really casual. Tricking, anonymous sex, fuck buddies—all concepts indulged in by gay men for years (at least until AIDS became a threat)—all seem like lovely ideas to me, but impractical, at least for the majority of lesbians at the current time.

It is more realistic for us to develop methods of enhancing sexuality within our primary relationships. Here we can borrow methods from heterosexual couples (through the literature on sexual enhancement within the sexology field) and from gay men. Briefly, I see three key elements: time, build-up, and variety. Time is the difficulty I encounter most frequently. Our culture promotes the concept of instant sexual turn-on. Most of us assume that sexual desire comes automatically in a relationship: Just as one gets hungry automatically, signaling a time to eat, so will we become lustful automatically, signaling an opportunity to have sex. In the limerance phase of a new relationship, this seems to be so. But, unfortunately, in an ongoing relationship sexual desire is usually not so automatic, nor is it so capable of conquering and overcoming fatigue, tension, or normal preoccupation with everyday affairs. And yet the typical couple assumes their sexuality will continue to function in an automatic fashion, and they consign the role of sexuality in the relationship to something that should occur, without planning, attention, or forethought, at the end of the day just before falling asleep. For most long-term couples, this method of handling sexuality is ineffective.

We pay less attention to our sex lives than we do to maintaining friendships, to planning meals, to physical exercise. It goes against the grain of all we have learned and all our cultural expectations to place this kind of priority upon sex, and it is particularly grating to us to plan for sex; it feels mechanical to us. But our sex lives suffer from the myth of spontaneity. As I mentioned earlier, I find one of the most positive benefits of assigning the sensate focus exercises to dysfunctional couples is that it forces them to set aside time to be alone without distractions, in a sensuous, physical way. Many couples will need to develop this concept of planned time alone together in order to preserve or bolster a faltering sex life.

Related to this concept of time is the idea of build-up. Just as desire between two people who have been together for some time is not automatic,

it is also not so easy in a long-term relationship to move from one state of consciousness, the one in which we conduct our everyday lives, to the state of consciousness in which we can feel physically relaxed, sensual, passionate. Most people, when not in a state of limerance or another high arousal state, need decompression time, and many women need build-up time. In other words, most of us need a transition period, a time when we take a bath, sit quietly and listen to music, have a glass of wine, and so on, so as to move from the attentional state required for work or taking care of daily business to a sexual state. And many women, in particular, need also to "simmer" sexually long before they actually become sexual: to think about sex during the day, have fantasies, anticipate pleasure and excitement, to build up their sexual desire before the actual encounter with the lover. I have found one of the strongest correlates of strength of sexual desire in women to be the frequency with which they think about sex. Very sexual women tend to think about or fantasize sexually many times during the day, and they tend to assess newly met people almost automatically on a sexual level. In other words, they view the world in more sexual terms, and they keep sex more in the forefront of their minds: They "simmer" themselves. Other ways for couples to build up tension and sexual excitement are to make sexual jokes or innuendos with each other, to touch each other sexually frequently even when there is no chance of continuing the touch to a sexual liaison, to talk about sex with each other frequently, and so on. This can help also to develop a sense of sex as play. Many women may think of sex as intimacy, sharing, or in other similar, serious ways; few women see sex as play, fun, and lightness. Developing a sense of sex as play is crucial if women are to participate in the third method of enhancing sex: increasing variety.

Michel Foucault said, in one of the last interviews before he died, "for centuries people have always spoken about desire, and never about pleasure. 'We have to liberate our desire,' they say. No! We have to create new pleasure. And then maybe desire will follow." It will be helpful to many lesbian couples to spend some energy introducing new pleasure, variety, and innovation in a playful way into their sex lives.

This can include the use of toys or props, everything from dildos and vibrators, lotions, and ice cubes, to cucumbers, feathers, silk scarves, to wrist and ankle cuffs and paddles. It can also include the use of mood-enhancers like music, candles, lighting, romantic dinners or settings. It can include dress-up, new places, or atmospheres. Variety might mean introducing simple or elaborate fantasies, simply recounted to each other or acted out: One couple told me they acted out a fantasy in vivo of meeting in a bar as though they were strangers. Written or visual erotica can help many couples enhance their sex lives: stories told to each other, "talking dirty" to each other, and so on. Some couples will want to develop and entourage fetishes: the playful use of leather, rubber, articles of clothing. Others will find it exciting to experiment with less usual, kinky techniques such as S/M, bondage, use of urine, and so on. It is not important whether the variety introduced is very innovative, creative, or far out, only whether it is novel to the couple. It may even be less important whether the innovation works than that the couple tried it: Many an experiment with a new technique or toy has resulted in both partners dissolving into laughter at the absurdity of what they are trying and then proceeding to have wonderful sex together. In some ways, what I am saying about sexual enhancement all amounts to the same thing: Making sex more rewarding for ongoing couples means making sex more of a priority, and making sex more of a priority means thinking about it more, talking

about it more, and setting aside more sensual, physical time together.

In some ways, lesbian sexuality needs to get more "male" in its orientation, with more emphasis on sex itself and perhaps less on romance. Trends in the lesbian community suggest that this is happening, and I see these trends as, on the whole, extremely healthy.

The therapist working with lesbians on their sexuality, whether to help solve sexual problems or to enhance a stagnant sexual relationship, plays a role not only with her or his clients, but also within the community at large. If our attitudes are sex-positive, sex-expanding, and playful, we model for the community a vision toward which we all can strive.

NOTES

1. Nancy Todor, "Sexual Problems of Lesbians," in *Our Right to Love: Lesbian Resource Book*, ed. Ginny Vida (Englewood Cliffs, N.J.; Prentice-Hall 1978).
2. Margaret Nichols, "The Treatment of Inhibited Sexual Desire (ISD) in Lesbian Couples," *Women and Therapy I* (Winter 1982); 49-66; JoAnn Loulan, *Lesbian Sex* (San Francisco: Spinster's Ink, 1985); Gail Kaplow, "Making Sex Better, a Therapist's Thoughts," *Sojourner* 10 (Aug. 1985).
3. Ann Snitow, Christine Stansell, and Sandra Thompson, eds.. *Powers of Desire: The Politics of Sexuality* (New York; Monthly Review Press, 1984).
4. Lillian Faderman, *Surpassing the Love of Men: Romantic Friendship and Love between Women from the Renaissance to the Present* (New York: William Morrow, 1981).
5. Philip Blumstein and Pepper Schwarz, *American Couples* (New York: William Morrow, 1983).
6. C. A. Tripp, *The Homosexual Matrix* (New York: McCraw Hill, 1975).
7. William H. Masters and Virginia Johnson, *Human Sexual Inadequacy* (New York: McGraw Hill, 1975).