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Sex Therapy with Same-Sex Couples

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Abstract

Same-sex couples are an increasingly prominent part of the United States committed couple population. Despite this, little research has been done on how to treat sexual concerns within same-sex couple relationships. As a result, therapists treating such presenting problems are often left unsure of best practices. The purpose of this study is to review the existing limited literature as it relates to knowledge therapists must have and things they should do in treatment. The study also presents a case study demonstrating the use of these practices and the Sexual Attentiveness & Accountability Model (SAAM) with a gay male couple.

Keywords: sex therapy, same-sex couples, LGBT couples, sexual dysfunctions, SAAM, Sexual Attentiveness & Accountability Model, sexual shame

Sex Therapy with Same-Sex Couples

Working with the sexual relationship is an integral part of doing couples therapy. Despite this, there is a historical lack of integration between sex and couple therapy practice, with many couple therapists either neglecting to bring up sexual issues with couple clients or referring their couple clients out to sex therapists when sexual issues emerge (Weeks & Gambescia, 2015). Therapists are often motivated to take such courses of action due to feeling inadequately prepared to work with sexual issues in therapy. However, these approaches do a disservice to clients. By purposefully neglecting to assess for sexual issues in couple clients, therapists ignore an integral part of their clients' relationship and arguably commit an ethical violation (American Association for Marriage and Family Therapy, 2004). By referring clients with whom the therapeutic alliance is already established to other practitioners when sexual issues surface, therapists risk further stigmatizing sexuality (Weeks & Gambescia, 2015). Due to these factors, it is required that all students graduated from accredited Marriage & Family Therapy programs are competent in treating sexual issues in their clients (Commission of Accreditation for Marriage and Family Therapy Education, 2017). However, it should be noted that, again, therapists both new and experienced feel unprepared to treat these issues despite the COAMFTE standards.

One population that is especially underserved in sex therapy is same sex couples, despite the growing prevalence of same sex individuals and relationships. Current estimates state that approximately 4.5% of the adult population within the United States are members of the LGBT community, with approximately 10,338,000 adults specifically identifying as lesbian, gay, or bisexual (The Williams Institute at UCLA School of Law, 2019). The most recent data on the number of same-sex couples in the United States come from the 2010 U.S. Census, which found

that approximately 594,000 same-sex couples lived in the U.S., equating to about one percent of all couple households (Lofquist, 2011). Given these numbers, it is statistically likely that therapists who work with couples will have couple clients where partners are the same sex or at least one partner identifies as lesbian, gay, or bisexual.

Despite the likelihood that couple therapists will see same-sex couples in practice, very little research exists on healthy sexuality within same-sex couple relationships, much less on how therapists can best work with same-sex couples to improve their sexual relationships (Lev & Nichols, 2015). Indeed, the very literature that clinicians use to diagnose sexual dysfunction, the DSM, is a prime example of heteronormativity in the field of sex therapy (Berry & Lezos, 2017). Within the diagnostic criteria for premature ejaculation, for example, there is a duration criterion for vaginal intercourse, but no duration criterion for anal penetration or other sexual activities that gay males may engage in (American Psychiatric Association, 2013). This lack of representation of same-sex couples within the sex therapy literature poses a problem for therapists working with same-sex couples presenting with sexual issues. Such therapists will often try to evaluate whether the principles they use in treating sexual issues in heterosexual couples will work with their sexual minority clients but will often have reservations about proceeding without the support of scholarly literature (Berry & Lezos, 2017).

The current paper aims to add to the current body of sex therapy literature by reviewing the existing research as it relates to knowledge relevant to clinicians and systemic treatment of same sex couples (both lesbian and gay couples) with sexual issues. The paper then presents a case study of a gay male couple with which such practices were considered and implemented.

Literature Review

Essential Knowledge for Working with Lesbian Couples

Prior research has identified several areas about which therapists should be knowledgeable in order to treat lesbian couples, one of which is the influence of patriarchy and male-centric sex. Patriarchal authority, an influence that has endured through the ages, can have a major effect on lesbian sexuality (Lev & Nichols, 2015). One of these effects is that very little is known about female desire in general, much less female desire in lesbian couples (Lev & Nichols, 2015). This effect extends into the lack of sexual scripts for lesbian women, for whom very few sexual scripts exist aside from those in pornography, where said scripts are typically male-centric and focused on appealing to the male gaze (Tiefer, 2001). These factors combine to make healthy lesbian sexuality largely invisible, which presents a unique challenge for lesbian couples and sex therapists alike (Iasenza, 2002).

Another area about which a therapist should be knowledgeable is gender expression among lesbians. For example, some lesbians prefer to behave and appear in more feminine ways (called “femme”), others prefer to behave and appear in more masculine ways (known as “butch”), and still others prefer a combination of the two (stud-femme or feminine butch) (Lehavot, King, & Simoni, 2011; Lev & Nichols, 2015; Levitt, Gerrish, & Hiestand, 2003). Therapists unfamiliar with these varied preferences may confuse such gender expressions with heterosexual posturing or a desire to take on traditional gender identities (Hertlein, Weeks, & Gambesia, 2009). Rather, such expressions are related to individual preferences and can also be a part of lesbian eroticism (Lehavot, King, & Simoni, 2011; Nestle, 1992; Russo & Owens-Reid, 2014).

An additional area where the therapist must have some knowledge is the reality of sexuality within lesbian relationships. Within popular culture, there is a notion that lesbian couples have sex less frequently than heterosexual or gay male couples (Iasenza, 2002). Sex

researchers have hypothesized that this popular idea could be caused by the heteronormative way in which sex is culturally defined, with factors such as penetration, orgasm, or genital contact usually assumed to be necessary in a successful sexual encounter (Lev & Nichols, 2015; Nichols & Shernoff, 2011). When other measures of sexual experience, such as time spent on sexual encounters, are taken into account, lesbian couples come out on top, indicating that the heteronormative ways in which sexual success is usually viewed may not provide accurate information about lesbian sexual functioning (Iasenza, 2002). This provides yet another example, along with the invisibility of lesbian sexuality and the misunderstanding of lesbian gender expression, of the lack of knowledge surrounding lesbian sexuality in general and especially in sex therapy.

Essential Knowledge for Working with Gay Male Couples

Research has also previously identified a knowledge base that therapists must have when doing sex therapy with gay male couples. One area of knowledge essential for therapists working with this population is the fact that there is so little research on healthy sexuality in these relationships. Although more is known about gay male sexuality than lesbian sexuality, much of the literature on male to male sexuality focuses on safe sex practices and prevention of HIV transmission (Lev & Nichols, 2015). Outside of this topic, there is a paucity of research on gay male sexuality, including many worthy topics related to healthy sexuality in committed relationships.

Sex therapists working with gay male couples should also be aware that gay men tend to experience higher levels of sexual dysfunction than heterosexual men. For example, one study found that 74% of gay men report sexual dysfunction as compared to 30-50% of heterosexual men (McDonough, Bishop, Brockman, & Morrison, 2014). A potential factor behind this

difference may include that gay men tend to have higher rates of anxiety about sex than do heterosexual men (Bancroft et al., 2005; Berry & Lezos, 2017). The elevated levels of anxiety could be due to the strong meaning attributed to eroticism in gay male relationships, as well as the internalized homophobia that gay men may experience (Bancroft et al., 2005; Berry & Lezos, 2017). Additionally, the concerns that gay men have are often different than those of heterosexual men due to the different sexual acts they engage in, such as pain during anal intercourse and HIV transmission (Nichols & Shernoff, 2011; Sandfort & de Keizer, 2001).

Another piece of knowledge therapists need to have when working with gay male couples is that gay male couples may express their sexuality differently. For example, gay male couples are more likely than heterosexual or lesbian couples to engage in consensual non-monogamy (Parsons et al., 2011; Shernoff, 2006). Gay male couples also tend to desire and engage in sexual behaviors more frequently than other couples (Lev & Nichols, 2015). Therapists working with such couples must be aware of these realities as well as their own biases about them in order to provide ethical treatment (Lev & Nichols, 2015). Acknowledging and confronting personal biases is a familiar concept for therapists, and should be consistently done in order to provide treatment to gay male and lesbian relationships.

Suggestions for Practice

In addition to the requirement that therapists have knowledge about their same-sex couple clients' unique experiences, cultural competence also mandates that therapists follow guidelines in the literature pertaining to therapeutic interventions. Because this research is still in its infancy, many of these guidelines revolve around the adaptation of sex therapy practices that are widely accepted for use with heterosexual couples (Barry & Lezos, 2017). Additionally, the

guidelines currently published in the literature are generalized to working with all same-sex couples as opposed to lesbian or gay male sexuality specifically.

The Sexual Attentiveness and Accountability Model

Despite the previously mentioned obstacles that exist in the current research, the primary recommendation for sex therapy with same-sex couples is the use of a modality that utilizes a systemic perspective. Indeed, Lev & Nichols (2015) propose that, when working with clients from marginalized groups (such as those in same-sex relationships), a systemic approach is the only appropriate choice. Other words used in addition to systemic include horizontal and multicontextual to describe their preferred lens when working with gay and lesbian clients and their sexuality (Bettinger, 2004; Berry & Lezos, 2017; Iasenza, 2004; Lev & Nichols, 2015; Rutter, 2012).

The Sexual Attentiveness and Accountability Model (SAAM) is such a model. Since the SAAM was utilized in the case study and is the guiding framework for this paper, it would be beneficial to give a brief overview of the model and its main tenets. The SAAM was originally developed by Anthony Hughes (2017) as one of the few systemic models for sex therapists. This model allows for both the individual their relationship by allowing for two different types of systems along with two principles used in treatment to navigate those systems.

The two systems are conceptualized (Hughes, 2017) as “systems from within” (p. 15) and “systems from without” (p. 17). Systems from within are contained within the individual, and the SAAM posits that there are four such internal systems: an individual’s spirit, physiology, psychology, and personality/characteristics. Issues within these systems can be highly correlated with sexual issues (Hughes, 2017). The systems from without are much larger (macro-level) than

the systems from within, and include an individual's upbringing, family life, religion, and many other systems from outside the person that can have an impact on the individual.

The effects of both systems can be difficult to navigate, which is why the two principles of attentiveness and accountability are integrated into the model. Attentiveness is conceptualized as awareness (Hughes, 2017), with the goal of being aware of how the above-mentioned systems impact an individual's sexuality. Often, one cannot control many of the systems and therefore cannot be accountable for some of the effects. However, being attentive to those effects can help the individual to negate their influence on the individual's sexuality.

Concerning accountability, or the individual's liability for their own sexual well-being (Hughes, 2017) and the systems within, an individual can become attentive and then accountable for the systems and their effects. Becoming aware of their accountability can be empowering for an individual as they take the initiative to work on their own sexuality. One thing to note is that acceptance is also a major part of this model; there are some elements of both the systems within and without that are out of the client's control and therefore cannot be accountable for. At this point, the clinician needs to aid the client in their journey towards their acceptance of said elements.

Role of the Therapist

Regarding the role of the therapist in working on sexual issues with gay male and lesbian couples, the literature suggests that therapists take on a collaborative, non-expert stance and feel comfortable with self-disclosure (Rutter, 2012). Such a stance can help gay and lesbian clients feel safe and affirmed by their therapist. The literature also recommends that therapists engage in regular reflective practice, which it acknowledges is especially important when working with traditionally stigmatized groups (Berry & Lezos, 2017; Rutter, 2012). Such a practice can help

therapists identify their own biases, giving them an opportunity for personal growth and alerting them to when it is necessary to seek supervision or refer clients to other providers (Berry & Lezos, 2017; Rutter, 2012).

Specific Interventions

Regardless of modality, there are key interventions that are recommended for use with same-sex couples. Many of these interventions have the purpose of reducing shame, which benefits clients several ways. First, because shame is such a large inhibitor of sexual desire, addressing sexual shame with clients who present with low desire is a crucial step in the treatment process (Longhofer, 2013; Lynch, 2015; Vaughan, 1999). Second, as sexual shame is addressed and begins to heal, clients may feel empowered to explore sexual preferences and create new sexual scripts. Exploration and the creation of healthy scripts that feel personally relevant are especially important for same-sex couples whose sexuality is often degraded, erased, and fetishized by the dominant culture (Iasenza, 2002; Lev & Nichols, 2015; Tiefer, 2001). Applying this idea to the SAAM, the feelings of shame which come from the narrative of the dominant culture (a system from without) could then become a part of the psychological system from within. As a part of either system shame could affect the sexual desire and relationships of clients.

There are several interventions that can be utilized to reduce shame, such as normalization (Berry & Lezos, 2017), horizontalizing (White & Epston, 1990), narrative deconstruction (Nichols & Davis, 2015), and the narrative technique of externalizing (Iasenza, 2004; Nichols & Davis, 2015). Because same-sex couples are part of a stigmatized minority population, the normalization of their sexual identity, sexual behaviors, and sexual difficulties can be especially powerful (Berry & Lezos, 2017). Along with that, horizontalizing – the process

of situating a client's presenting problem within the wider context of their lived experience – is similar to the narrative intervention of reframing the client as multi-storied rather than single-storied (Berry & Lezos, 2017; White & Epston, 1990). Helping clients see and understand their problems in this manner can reduce shame by expanding the focus of therapy beyond the client's sexual identity and sexual dysfunctions (Berry & Lezos, 2017).

The narrative technique of deconstructing negative cultural assumptions (Nichols & Davis, 2015) is also very helpful. Many same-sex couple clients experience internalized homophobia as a result of the culture they grew up in, which can then produce shame about sexual desires and behaviors. Examining and deconstructing the sources of this internalized homophobia can reduce shame and promote self-acceptance (Hall, 2012). Finally, through the narrative technique of externalizing, clients are able to acknowledge the problem as the problem rather than themselves as the problem, which can help to reduce the shame rampant in issues of sexuality (Iasenza, 2004; Nichols & Davis, 2015).

Case Study: A Systemic Approach to Low Sexual Satisfaction in a Gay Male Couple

Scott and Kyle were a gay couple in their 30's. They did not have any children, and both partners worked full-time. They came to therapy because neither partner was happy in their sexual relationship. Over the course of dating, they had an active and enjoyable sexual relationship, but as time went on and they were together for longer, they each felt less sexually satisfied. Scott reported that as he became less sexually satisfied, his sexual desire decreased as well. Kyle reported still having a strong sexual drive, but he rarely initiated sex with Scott. Rather, Kyle's sexual interest was primarily in those outside of his relationship.

Historically, Scott and Kyle had decided that it would be permissible to have sexual relationships outside of their partnership. Scott had participated in sexual activities outside of

their relationship several times before he began experiencing a decrease in his sexual desire. He reported that different aspects of these relationships had been unenjoyable due to feelings of shame. Kyle had continued to pursue such sexual encounters while on business trips, but he found that his interest and the encounters themselves were full of guilt for him. He wanted to have the occasional extra-relationship encounter, but his primary desire was to have an active and enjoyable sexual relationship with Scott.

Assessment and Conceptualization

Assessment revealed that a multitude of systemic factors from both within and without were interacting to create the discontentment in Scott and Kyle's sexual relationship. Scott had grown up in a conservative, highly religious family and community. Because of this, Scott experienced internalized homophobia and had to disconnect in many ways from the sexual activities he engaged in in order to enjoy being with Kyle. Starting in his teens, Scott had explored his sexuality in shame by secretly watching male on male pornography and eventually using hook-up apps for men. He eventually had a few brief relationships with men that revolved around sex. Scott only rarely brought his short-term partners around family or friends or went out with them in public for fear of being seen together. This continued until Scott was introduced to Kyle through friends in his early 30's.

Kyle had also been raised in a conservative, religious community. However, his experience differed from Scott's in that he had parents, family, and friends who were accepting of his sexuality. While Kyle engaged in behavior similar to Scott's by having sexual encounters with men who he met through hook-up apps, he also nurtured other aspects of his intimate relationships and had several monogamous relationships with men before meeting Scott. Kyle had more knowledge of himself as a person, a sexual being, and a partner than Scott. Kyle could

ask for what he wanted sexually without feeling shame. He struggled with Scott's internalized oppression because of his different experience, and it was very difficult for him when Scott would not hold his hand in public or kiss him around his family.

Interventions

Deconstructing Narratives & Cultivating Self-Compassion

Scott worked to understand the damaging narrative about his sexuality that his culture had exposed him to and how this dominant discourse was affecting him (Nichols & Davis, 2015). He worked to overcome seeing himself as "other" and the internalized oppression and shame that this caused. Scott did this by cultivating self-compassion and self-acceptance. Through this, he was able to experience sexual activity as enjoyable without "turning himself off" due to the shame he felt about participating in these acts. As a result, Scott was able to develop his erotic template and create a new, healthy sexual script.

Processing Unresolved Pain from Past Relationships

During the process of therapy, it was revealed that Kyle had some unresolved fears created by past relationships that came up when Scott would refuse to be affectionate with him in public or would discuss his sexual shame. Past boyfriends had left Kyle to due to uncertainty about their sexual orientation. This created a fear in Kyle that he would never find a partner who was sure enough of his sexual orientation to want to stay together long term. Kyle was able to resolve this pain and fear through sharing it with Scott and understanding how Scott's shame around his sexual orientation differed from questioning his sexual orientation.

Building Emotional Safety in the Couple Relationship

Increasing emotional safety in the couple relationship was key in the healing process for both partners. Scott needed emotional safety in order to explore the pain and shame he felt

around his sexuality. Kyle was able to create this safe environment for Scott through acceptance and witnessing of Scott's process and story. Kyle needed emotional safety in order to provide this acceptance and witnessing for Scott without having his fears of being left generated by past relationships triggered. Scott was able to provide this emotional safety for Kyle through reassurance of his love and commitment to him. As the partners learned to communicate openly and respectfully about their shame and fear, they each had the opportunity to extend emotional safety to the other that assisted in the healing process for each.

Enhancing Outside Support

Along with addressing their internal and external systems, it was also necessary for them to gain a more supportive external system. By gaining this supportive external system, positive feedback loops could be created to help reinforce the positive changes made by Scott and Kyle. This supportive external system could also create alternative narratives about sexuality that were conducive to Scott accepting his sexual interests and desires and continue his sexual exploration. Gaining a supportive external system could be accomplished by opening up to supportive friends and family about the struggles they had been experiencing (both individually and as a couple) and insights gained during therapy.

Conclusion

Despite the lack of research on doing sex therapy with same-sex couples, it is statistically likely that therapists who work with couples will encounter a same-sex couple client experiencing sexual issues at some point during their careers. The case study demonstrates some of the recommendations for best practice that currently exist in the literature for working with such couples. One central recommendation is that therapists use a model that accounts for the various systems in which clients operate. This paper suggests the SAAM as a model that assesses

and treats both the individual and external systems of each partner. Another central recommendation is the use of interventions centered around reducing sexual shame. As shown by the case study, interventions such as deconstructing cultural narratives, increasing self-compassion and acceptance, and examining narratives created by past experiences allowed the couple to reduce and heal unresolved shame.

Finally, therapists must assess the level of support that couples receive from their external system. If clients are able to open up to supportive friends or family members, their experience of rejecting internalized shame can be reinforced. It is the authors' hope that as these recommendations are followed and more research on sex therapy with same-sex couples is conducted, therapists can help their same-sex couple clients to enjoy happy, fulfilling sexual relationships.

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