

What is Queer About Sex?: Expanding Sexual Frames in Theory and Practice

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Psychotherapists often believe if couples improve their communication and emotional dynamics, good sex follows. In practice we often find otherwise and have many questions about how to proceed to work with sexuality issues more directly. This paper presents the many challenges working with sex including the following: the fluidity and multidimensionality of sex and gender, the incongruities and paradoxes in sexual behavior, thoughts, attractions, feelings, and sensations, and the powerful feelings, impasses, surprises, and confusion therapists often experience doing the work. In essence, what is queer about sex? Using the couple as client, expansive ways of thinking and working with sexuality are presented including the development of inclusive models of sex, gender, and sexual response, as well as new approaches to standard sex therapy techniques such as sexual history-taking, redefining sex, and sensate focus. Techniques are presented with an emphasis on the therapist's use of self as sexual change agent including integrating multiple theoretical perspectives (psychodynamic, systemic, and cognitive-behavioral), co-creating a safe treatment frame, and how to intervene within the cognitive, affective, behavioral, somatic, and discursive realms.

Keywords: Queer; Sexual Fluidity; Couples and Sex Therapy; Gender Diversity; Sexual Menu

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Sex is a queer experience for everyone at one time or another. It can be unruly, ecstatic, routine, mysterious, transgressive, confusing, unpredictable, and changeable over the lifespan. It defies easy generalization, categorization, and explanation. Most of us think of queer experience as relating to gay or lesbian experience or as gender nonconforming experience. The term “queer” has carried various meanings throughout history—a mid-20th century epithet for gay people, a reappropriated anthem for 1980s gay/lesbian activism, and a rejection of sex/gender binaries in more recent times.

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Queer will be used in this paper in three ways. First, it reminds us of the potential fluidity and multidimensionality of same and other sex/gender experience in all people. Such a therapeutic conceptual frame creates safe space for clients to (re)imagine themselves in whatever inclusive or expansive ways they need. Second, it embodies the confounding nature of sexuality in general with its incongruities and paradoxes in sexual behaviors, attractions, thoughts, feelings, fantasies, and sensations. Thirdly, it normalizes our awkwardness as we challenge our own cherished frames about sexuality and gender in clinical practice. Working with complex sexual issues requires utilizing multiple theoretical perspectives (psychodynamic, systemic, cognitive-behavioral) as well as integrating clinical interventions that operate within the cognitive, affective, behavioral, somatic, and discursive realms. This includes tolerating “queer moments” in therapy when we feel perplexed, off balance, or uncomfortable with the impasses, intensities, and surprises that often develop within expansive erotic space.

Therapists often believe, as I did for many years, that if couples improve relationship dynamics, good sex will follow. Sometimes it does when conflict is replaced by empathic communication or better negotiation skills. However, when couple dynamics improve but sex does not, we often feel a need for additional knowledge and skill to help clients and are left with many questions. What theories would help guide the work? What techniques would increase our ability to effect change? How can we feel comfortable asking questions about the most private intimate parts of people’s lives? What questions should we ask and when should we ask them? What do we do with the information once we collect it? How do we identify and work with sexual shame, wounds, and boundary transgressions in clients’ past experiences that affect their sexual lives now? How do we deal with queer (potentially queasy) moments when our own feelings of attraction, repulsion, boredom, excitement, confusion, or surprise emerge when working with sexuality?

Our clients present with many queer scenarios that can challenge our best efforts to remain nonjudgmental. Here are some examples.

Explicit descriptions of sex, details of sex with someone of the same sex, sexual feelings for both men and women, feeling one’s biological sex does not match one’s gender identity, being happy with one’s biological sex but wanting to be socially experienced as someone of the other sex, sexual attraction to someone who is changing gender, not identifying as either gender, not able to desire someone one loves, never having experienced sexual desire in one’s life, only enjoying sex when imagining oneself as the other gender, a heterosexually married person having an affair with someone of the same sex, lesbians who have sex with men, a gay man who fantasizes about women when having sex, someone who likes physical pain or violence with sex, men who like to have sex wearing women’s clothing, heterosexual men who desire anal penetration, or someone who becomes sexually excited by being humiliated. The list goes on and on. Additionally, increased accessibility to sexual images and practices through the Internet has made the discovery of and indulgence in queer sexual experiences much easier in recent times.

Sexuality and gender are such loaded issues in our culture, within families, intrapsychically, and interpersonally, keeping our own heads, hearts, and bodies engaged when most of us receive little or no human sexuality training is an awesome task. This paper will provide theory and techniques suitable for couple and family therapists that respect the diversity of sexual experiences while guiding the therapeutic process.

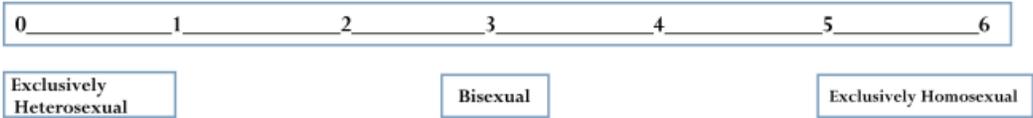


FIGURE 1. Kinsey et al. (1948): Sexual Orientation Continuum (Behavior and Attraction Combined)

EXPANDING MODELS OF SEXUAL BEHAVIOR

When the Kinsey studies on male and female sexuality were published in 1948 and 1953, respectively, a definitional crisis occurred. Before Kinsey, public and scientific communities considered same sex activity an uncommon behavior engaged in by psychologically or morally limited individuals. Sexual behavior placed a person in one of two categories, heterosexual or homosexual, which were believed to be immutable essences of an individual. Even though Freud (1905/1953) presented the idea of inherent bisexuality decades earlier, it hardly took hold in the public imagination until Kinsey and his associates provided empirical evidence for a sexual orientation continuum (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953).

The Kinsey Heterosexuality–Homosexuality Scale was created to describe sexual orientation on a 7-point continuum (0 = *exclusively heterosexual* through 6 = *exclusively homosexual*) based on reports of sexual behavior and sexual attraction in Kinsey’s subjects (see Figure 1).

Kinsey documented a significant incidence of homosexual behavior and responsiveness in males and females. Most combined responses fell in the “bisexual” middle of the continuum. Kinsey argued that humans, like other animals, have the capacity for same and other sex involvement which may be actualized to different degrees, behaviorally or affectively, at different times over the lifespan.

Despite its profound impact, subsequent researchers identified limitations with Kinsey’s continuum, most notably that he only studied two aspects of sexual orientation, sexual behavior and sexual attraction, which he assumed were congruent within the individual (Coleman, 1988). Newer models, like the Klein Sexual Orientation Grid (KSOG; Klein, Sepekoff, & Wolf, 1985), contain more aspects that represent our understanding of the greater complexity of sexual orientation.

The KSOG was developed to extend Kinsey’s work by conceptualizing sexual orientation as a multivariable dynamic process. In addition to sexual behavior and sexual attraction, Klein and his associates defined five other aspects: sexual fantasy, emotional preference, social preference, sexual self-identification, and heterosexual/homosexual lifestyle preference, making for seven aspects in all (see Figure 2).

Individuals rate their experiences on 7-point continua. Additionally, the KSOG measures these aspects in relation to the past (your life since age 20), the present (your life

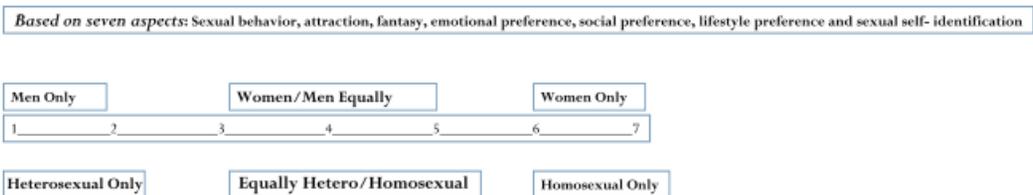


FIGURE 2. Klein et al. (1985): Klein Sexual Orientation Grid



FIGURE 3. Lev's (2004) Model of Sexual Identity

within the past 12 months) and the ideal (where you would like to be on the continua), providing an assessment of the changeability of sexual orientation over the lifespan.

The KSOG may be used clinically to help clients explore the complexity and fluidity of sexual orientation. It is particularly helpful with couples who feel unsettled by variability in sexual orientation in either or both partners. Besides providing clarity about an individual's sexual orientation, it normalizes the incongruity and changeability of same and other sex eroticism without forcing a particular meaning onto any given behavior, feeling, or fantasy. It avoids foreclosure of self-identification and supports the position of not claiming a set identity at all. When utilized in treatment, clients learn to explore dreams, fantasies, wishes, and feelings in an open curious way.

A similar conceptual approach is useful when appreciating diversity in gender identity, experience, and expression, one that deconstructs gender binaries (Burdge, 2007; Lev, 2004). Lev offers a model of sexual identity consisting of four components: sex (male–female), gender (man–woman), sex role (masculine–feminine), and sexual orientation (heterosexual–homosexual) that are flexible, exist on continua, and help us better understand gender-variant behavior and experience (see Figure 3). It represents a shift from a binary system consisting of two sexes that are opposite and different from one another to one where sex and gender are socially constructed and potentially fluid.

What is important about Lev's model is it not only normalizes transgenderism and transsexuality, which is sorely needed in psychotherapy practice, but also provides an expanded sex/gender approach for all people. Within this expanded potential space (Winnicott, 1971) where one is safe to explore and play, what might have been shamefully repressed becomes available for integration. For example, a heterosexual man may describe his female experience when his wife licks his nipples, or a bisexual woman may expose her wish to experience her masculine power by penetrating her husband during anal sex. What a gift we offer our clients when we co-create safe space for them to investigate whatever sex/gender erotic combinations emerge in fantasy, feeling, or behavior (except for coercive or harmful behavior).

Human Sexual Response Models

Nowhere are models of sexuality more influential than in our belief about what constitutes healthy sexual response. Like Kinsey, another team of researchers from the Midwest profoundly set the direction of how we think about sex. In the 1950s and

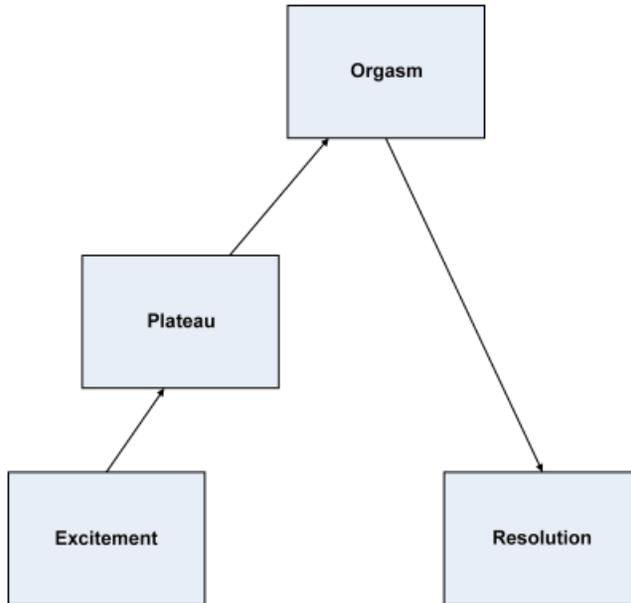


FIGURE 4. Masters and Johnson (1966) Human Sexual Response Cycle

1960s Masters and Johnson set out to document what constituted healthy sexual response. In a remarkable scientific feat at that time, they observed hours of laboratory-performed sexual activities by willing participants. The result of their effort was the development of the Human Sexual Response Cycle (HSRC) consisting of four phases of sexual response (excitement, plateau, orgasm, resolution) that they believed all men and women went through during sex (see Figure 4).

The HSRC focuses on genital phase functioning with orgasm as the goal of sex. Masters and Johnson (1966) believed that effective physical stimulation and removal of inhibitions was all that was required for successful sexual functioning. They helped develop sex therapy as a brief problem-focused therapy with sensate focus (progressive touching exercises) as its main technique. Despite its popular appeal, the HSRC is quite limiting in its linear structure and its genital/orgasm focus. Many clients feel dysfunctional not because they really are, but because their own sexual responses do not conform to the HSRC model. What if someone never experiences orgasm but feels very emotionally satisfied with sex? What if someone prefers nongenital over genital sexuality? Are these experiences dysfunctional? Many people (or their partners) think so.

An important addition to the HSRC occurred in the 1970s when psychoanalyst/sex therapist Helen Singer Kaplan insisted that sexual desire become the first phase of the cycle (Kaplan, 1979). She observed disinterest in sex as an important phenomenon, especially in her female patients. We now appreciate her contribution since so many presenting problems involve desire. The expanded HSRC is still limited by its linear phase structure and orgasm endpoint. Despite cogent criticism of the HSRC, on scientific, clinical, and feminist grounds (Tiefer, 1995), it remains, with Kaplan's addition, the template for understanding sexual dysfunction in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994).

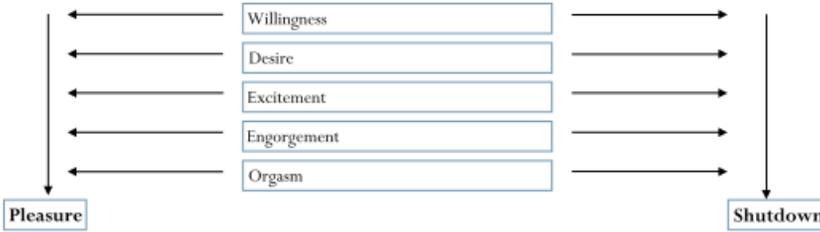


FIGURE 5. Loulan's (1984) Sexual Response Cycle

A sharp departure from the expanded HSRC was offered in the 1980s by Joanne Loulan, a researcher in female bisexual and lesbian sexuality. Loulan (1984) developed a nonlinear female sexual response cycle that included the traditional sexual response phases but began with *willingness* instead of desire and ended with *pleasure* instead of orgasm (see Figure 5). This model represents a remarkable expansion in conceptualizing sexuality based not just on physical response but as an experience consisting of subjectivity and agency.

Loulan contends that people can *decide* to have sex not wait until they feel “horny.” This offers a revolutionary option, especially for women who lose sexual desire over time in committed relationships. The willingness concept also gives hope to male and female survivors of abuse who often find desire an elusive, fraught experience. Willingness, for survivors, offers a sexual option that includes control, volition, and a way to communicate a *cognitive or emotional desire* for their partner when the body cannot. Loulan's model allows for shutdown at any point in the cycle and includes a definition of pleasure consisting of cognitive, emotional, and physical experiences. Armed with this model, therapists can help clients develop curiosity about their own phases of sexual response in whatever order they emerge, their own style of initiating sex drawing from cognitive, emotional, or physical sources, and their uniquely subjective definitions of pleasure.

The latest conceptual revolution in understanding sexual response, contrary to what Masters and Johnson believed, emphasizes that male and female sexuality are very different. Researchers, Rosemary Basson for one, have identified gender differences in sexual motivation, sexual concerns, sexual arousal, and sexual desire (Basson, 2002; Chivers, 2005; Hill & Preston, 1996; Laumann, Michael, & Gagnon, 1994).

Unlike Loulan's model, which remains known mostly within feminist and sexual minority communities, Basson's (2001) female sexual response cycle has entered mainstream sex therapy literature, challenging the traditional 4-phase linear (male) DSM desire–arousal–orgasm–resolution model. Basson's circular sexual response cycle includes components such as multiple reasons for initiating or agreeing to sex, willingness to be receptive, psychological and biological influences on arousability, and the idea that arousal may precede and then accompany desire. It is this last point that is most revolutionary along with Basson's differentiation between “spontaneous desire” (innate drive) versus “responsive desire” (contextual/relational), and her recognition of the importance of subjective arousal versus genital lubrication/swelling (see Figure 6).

I offer Loulan's and Basson's models to all my clients (male, female, in-between, neither). I often do this when discussing a treatment frame by saying something like

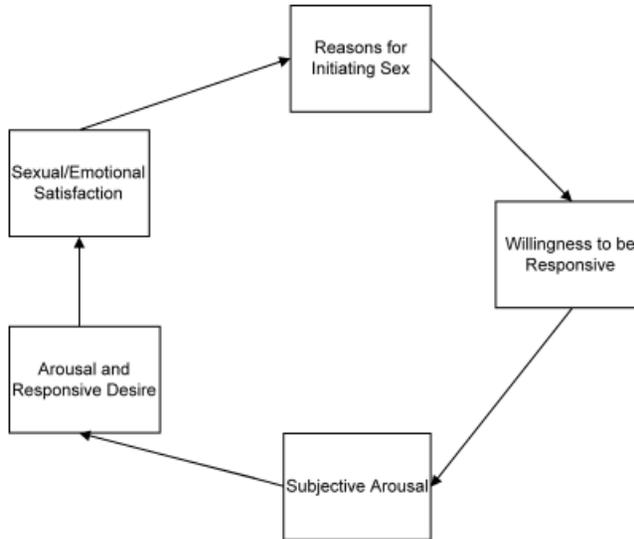


FIGURE 6. Components of Basson's (2001) Female Sexual Response Cycle

the following: "In this culture we are offered only one model of sexual response that starts with desire includes genital sex and ends with orgasm. This can often feel restrictive and can create counterproductive levels of performance or response anxiety during sex. More recent models challenge that linear model and question whether those stages happen in that order and if other goals for sex, like pleasure or emotional connection, are equally valid. As we work together I encourage you to think about alternative views as you see fit so you may discover, define, and understand your own unique sexual responses."

The overall purpose is to help clients realize how people often behave according to some theoretical frame or another (not in some natural universal way) and to identify the impact models have on our sexualities. Do we consider orgasm as the only or best goal? Is genital sex considered to be the "real thing"? Is all else a prelude to it? Is masturbation "sorry seconds"? Is genital or anal sex incomplete without penetration? I often find that clients of all genders who already feel sexually ineffective welcome the opportunity to feel more sexually competent even if it takes time to appreciate their own responses and those of their partner without judgment or pressure to measure up to the "right" sexual response.

A caveat is necessary lest we become too enamored with the notion of "real" gender differences, suggested by Basson's work, because group comparisons often obscure important within group differences. Helpful here are the thoughts of relational psychoanalyst Adrienne Harris (2005) who, in her book *Gender as Soft Assembly*, offers a vision of gender as consisting of "shifting constructions" and everyday "contradictions" instead of natural stable binary categories. She encourages us to think of our clients' subjectivities as including multiple genders and embodied selves that are configured within multiple contexts over the lifespan. If one works with diverse couple populations—gay, lesbian, bisexual, heterosexual, transgendered—one often observes how supposedly gendered experiences and expressions can shift within individuals depending on context, relational dynamics, sexual activities, or self-states,

which for some clients feels too “queer.” This will be illustrated with case material in the next section.

EXPANDING THERAPEUTIC PROCESS

Creating the Therapeutic Frame

Most couples I see present with sexual issues as all or part of their concerns. I set the tone for discussing sex by ensuring that the first session consists of a discussion of each partner’s view of their sexual problems as well as their hopes and fears about sexual change. Asking about sex in the first session gives clients the message that you are comfortable talking about sex and would not let it be sidelined by other presenting problems. Even with couples for whom all is well sexually, exploring the sexual area during assessment lets them know you are open to discussing sex in the future and helps identify skills that the couple can utilize in weaker areas of their relationship.

As couples begin to discuss sex I listen for how the couple conceptualizes their sexual problems, including how attached a couple is to a healthy versus “identified patient” frame. It is common for both partners to believe that one is more responsible especially if he/she presents with an identifiable sexual issue like low sexual desire, erectile problems, or painful penetration. This is when good couples therapy skills are essential, including creating a safe holding environment where the therapist maintains a balanced position and explores multiple levels of individual contribution to couple dynamics (Scheinkman, 2008), from intergenerational patterns (Bowen, 1978) to internalized object relations (Scharff & Scharff, 1991). I explore with partners what they each need to safely work on sex. With high conflict couples safety requires changing communication patterns that create an anti-erotic relational environment. My goal is to construct a safe enough therapeutic container (Bion, 1962) within which shamed, wounded, and disowned parts of the self can be revealed, worked through, and integrated.

At the end of the first session I raise the issue of taking complete sexual histories. I usually say something like: “In order to work more deeply on your sexual issues, I will first need to meet with each of you separately to gather complete family, sexual, and relationship history so we can understand how each of you became the sexual beings you have become, both before you met each other and since. We will use the information gathered in the histories to better understand how your sexual problems have developed and will also identify resources that may help.” At this point if one or both partners ask whether the history information will remain confidential I initiate a conversation about privacy versus secrecy (Imber-Black, 1998). There are some areas of inquiry that are important to explore with me (i.e., sexual fantasies) that are private and do not need to be disclosed to a partner. Information that is secret (something going on that negatively affects the relationship or violates an agreement between the partners), if shared with me, would be discussed to understand what it means, how it affects the couple relationship, and if/how to proceed with couples therapy.

From the beginning of therapy, I create expansive erotic space by inquiring about, exploring, and, if necessary, normalizing, and reframing queer experiences in couples or individual sexual history sessions. Queer experiences may be conscious or unconscious, openly discussed or hidden sources of sexual difficulty. Distress about fluidity of same and other sex/gender experience or incongruities in sexual behavior, attractions, thoughts, feelings, fantasies, and sensations varies across individuals and

between partners. I use therapeutic sexual history-taking, methods of deconstructing sex, and mindfulness sensate focus to help couples create a good enough sexual style to deal with the queerness of sex over time (for more information about the basics of how to structure treatment for various sexual problems see the work of Levine, Risen, & Althof, 2003).

Harold and Martha, a couple in their 50s, entered sex therapy to understand why their sexual life began fizzling 1 year into their 5-year marriage. They were confused about the decline given an initial passionate 12-month honeymoon period and a longstanding mutual sexual attraction. Other than their avoidance of sex, they thought their relationship was strong, describing it as highly affectionate, companionable, and enjoyable. Having no children enabled them to indulge in an active life of travel, sports, and cultural events. Harold, a handsome 6-foot tall ex-college football star businessman, had many sexual conquests in his younger years that seemed to bolster his manly self-image. Despite all of his sexual success, Harold had few long-term relationships and his first marriage ended sadly with his wife leaving him. Martha, an attractive slightly built successful investment banker, also knew heartbreak when her first husband left her for another woman. A Phi Beta Kappa graduate of an Ivy League college, Martha said she never felt sex appeal was her strength, had few sexual relationships, but always liked sex.

I asked them how they defined “sex” and, after describing the different sexual response cycles, what sexual response model they worked from (performance based, pleasure based, or connection based). They laughed and admitted that they were driven people in business and in bed, and sex reflected it. They felt compatible in their routine with Harold initiating kissing, touching, and intercourse. Both masturbated occasionally. They never discussed sex.

Harold and Martha’s treatment goal was to increase sexual frequency. The catalyst for coming to therapy was the divorce of their closest couple friend. They feared if sex did not return, they might not be able to stay together. When I explained my need to see them separately to conduct sexual histories they readily agreed and set up separate appointments for the following week.

Sexual History as Therapeutic Narrative

The sexual history is a standard sex therapy procedure whose main purpose is to assess the development of sexual dysfunction (Wincze & Carey, 1991). Sometimes given to clients to fill out at home, standard questions focus on the biological, psychological, and social influences on sexual development. I use the sexual history process, which usually takes two to three sessions, as a narrative therapeutic intervention as well as a form of assessment. I play various roles: interviewer, empathic listener, sex educator, and co-meaning-maker. For many of my clients of all ages, the sexual history is the first time they thought and shared about their development as sexual beings.

Below is my loose topic guide that includes expanded attention to sex/gender issues and incorporates a multicontextual perspective (Carter & McGoldrick, 1999), one that not only views presenting problems from an individual or couple perspective, but also includes an appreciation of the familial, community, and societal influences on sexual experience. I take care to inquire about the following areas not by posing a list of

questions, but by engaging in a fluid conversation. I pay particular attention to an individual's feelings about and meaning-making of their experiences.

Childhood: type of relations with family members; parental relationship; gender experience/identity/role; peer relations; first sexual feelings (same and/or other sex); masturbation; peer sexual play; sex education (how learned about sex); religiosity, race/ethnic/class experience; messages about sex; how affection was shown; how nudity/body issues were handled; how privacy was managed; how boys and girls were treated; any unpleasant, confusing, embarrassing, or disturbing sexual experiences; medical treatments in self or family members; sexual/physical/verbal/emotional abuse or neglect; substance use.

Adolescence: peer relationships; school experience; experience of puberty; body development & image, menstruation; pregnancies or abortions; wet dreams; dating; self-esteem; masturbation (methods and fantasies); sexual behavior and attractions (heterosexual, homosexual, bisexual, pansexual); coming-out experiences; first intercourse/sexual experience; substance use.

Adulthood: medical history (including psychiatric treatment and psychotherapy), relationship history; sexual experiences; masturbation; fantasies; dreams; sexual problems (in self or partners); STDs; HIV status and safer sex; birth control; children; menopause; medications; substance use; occupational history; peer/family relations; coming-out experiences at home and work.

Societal Influences: the effects of biases based on race, ethnicity, sex, gender identity/role/ expression, class, sexual orientation, religion, age, disability, and family form.

Current Sexual Functioning: current sexual functioning; areas of strength, difficulty, or concern including any recent changes in the above, sexual preferences, likes and dislikes about the partner and/or self, monogamy, non-sexual activities (individually and as a couple), communication about sex, intimacy, and affection.

I begin a sexual history by asking, "As far back as you can remember, what is your first memory of sexuality?" After getting the details of the memory, I ask about feelings and sensations at the time, if he/she was discovered or told anyone about the experience, and if so, how the other reacted. Throughout the history I track themes of shame, guilt, and boundary violations, defined as anything that made the individual feel out of control, scared, disrespected, or hurt in relation to their sexual/body/self-integrity. If the client identifies a particular experience that contains these themes, I then ask, "How do you think that experience affects your sexual life now?" I participate with the client in reauthoring (White & Epston, 1990) their sexual narrative to include reframing aspects of their sexual life that contain shame and self-criticism.

I enter a history process wondering, "What is being contained for this person through the maintenance of the couple's sexual problem?" What childhood dynamics, like the internalized parental couple, are influencing sexuality (Iasenza, 2006)? What core erotic themes (sexual scripts and turn-ons) developed in early life (Morin, 1995)? How are attachment needs or fears being reenacted, or defended against? Is the sexual problem an attempt at reparation from a past wound or mastery over some trauma (Stoller, 1975)? These are some of the processes that I often hypothesize about with a client before ending the individual sessions.

When Harold arrived for his first individual session he seemed sheepish. He acknowledged his lack of experience talking about sex apart from typical boasting with

male peers. The middle of three boys, he attributed silence about sexual discussions to his ex-Marine father's stoic toughness and his mother's genteel WASP style. His early childhood experiences were unremarkable to him. His earliest sexual memory was playing doctor with neighborhood kids. He reported no memories of shame or boundary transgressions. Throughout the session Harold commented about my nonchalant style talking about sex. He expressed amazement and appreciation that such an open conversation was possible. I grew curious about Harold's expression of these feelings and wondered if they held some deeper meaning for him.

It was not until the middle of his second individual session that the reason for Harold's appreciation revealed itself. I asked him why his first marriage ended. He painfully confessed that it was his fault. Half way through his 10-year marriage he periodically began losing erections, forcing him to change his typical sexual script, consisting of initiation and intercourse, to one consisting of more expansive foreplay. In the receptive role he became aware of heightened arousal when his wife played with his nipples and poked his anus. What shook him was an accompanying fantasy where his wife became a female top making love to him as a female bottom, his penis transformed into a throbbing clitoris, her finger in his anus became a dildo entering his vagina. "I felt like I was having lesbian sex with my wife, for God's sake, and I stopped it by withdrawing from sex," he exclaimed with embarrassment.

This unexpected disclosure created a queer moment for me that I handled by taking a breath and putting myself into Harold's queer experience wondering what meaning it held for him. I then asked, "What do you think is most challenging for you about that experience?" Harold halted and sat in silence, then smiled, saying, "This is just one more discussion about my sexuality to explore, isn't it?" "Yep," I replied, "It's not so unusual for people to experience different gendered states especially during sex."

Harold talked about feeling torn between attraction and shame about his fantasy, and fear about how it might ruin his relationship with Martha. His masturbatory fantasies only consisted of heterosexual sex. We tried to understand the beginnings of his new fantasy and wondered if the vulnerability of the erectile changes supported its development or vice versa. I wondered aloud to Harold if his strict intercourse script was more of a defense against vulnerability than a preference. He willingly let himself associate to that and moved into how painful it was to see his gentle mother handle his father's overbearing way. "Perhaps I'm a man torn between acting dominant like my father but preferring the gentleness of my mother. I really felt for her even though I never let on about it," he declared. I told Harold that it is not a surprise that his fantasy showed up within a committed relationship where most people's internalized wishes, fears, and conflicts from childhood reemerge. I added, "You couldn't with your ex-wife, and can't now with Martha, keep up the dominant role completely. Being committed long-term often requires embracing vulnerability and your lesbian experience exists to help you accept and integrate that part." Harold was intrigued by my different perspective and said he would think about it.

Martha's sexual history revealed a theme of needing to feel desired as an attractive woman. She grew up with an older sister "prom queen type," Jane, who was favored by both her parents. Jane bonded with their mom around domestic activities (Martha was a tomboy), and their Dad showered Jane with compliments about her looks and popularity. Martha felt like the ugly duckling loner at home. She excelled at sports with boys in the neighborhood, which contributed to her confidence and skill competing in a male-dominated career later in life. She married late, at 40, to a man who

devastated her by having several affairs. “He told me my best asset was my mind. I felt like a failure as a woman.”

When Martha met Harold at a party she felt like “the sexiest woman in the room the way he looked at me. He was surrounded at the bar by several attractive women and he left the party with me. I felt like my time had finally arrived.” After a short courtship they married and Martha had high hopes to fulfill her dream of romance. Sex was wonderful at first but as Martha perceived Harold’s gradual retreat from sex, “my feelings of failure as a woman painfully resurfaced. I feel it every day.” I added, “I’d imagine that the pain originates back to when you felt so rejected and alone in your family.” “Yes,” she said sadly, “I used to feel so ashamed when my father complimented Jane right in front of me, as if something was wrong with me.” “And how did you deal with it then?” I asked. “The same as I do now, I retreat,” she said. As I finished her sexual history I realized that Martha’s sensitivity to rejection and her desire to feel desired outweighed any particular preference regarding sexual activities or roles. Although she relied mostly on intercourse, she was open to a greater variety of sexual items including oral and anal sensuality, and foreplay involving breast/nipple play and sensual touch.

Harold and Martha were suffering from a sexless marriage caused by false assumptions, shameful secrets, and painful defenses and reenactments from their childhoods, which was compounded by poor communication skills. Harold’s shame and conflict about his queerness (and the vulnerability it represented and created) caused him to withdraw from sex, which triggered Martha’s feelings of rejection and failure as a woman. To cope, she retreated, which intensified Harold’s fear that his queerness would ruin their relationship. Harold and Martha’s strengths included their continued sexual desire for each other and their companionable relationship that I hoped could be tapped as a resource during sexual assignments.

Creating a Treatment Frame

In the session following the completion of sexual histories, I share parts of each person’s history, with their prior permission, for the purpose of opening discussion and fostering understanding about the development and/or maintenance of their sexual problem. I reframe their sexual problem as an opportunity for growth and repair for them as individuals, providing emotionally corrective experiences that were missing from their pasts (Schnarch, 1996). I do this by saying something like: “Oftentimes our most difficult sexual issues contain parts of our past experiences, conscious or unconscious, that are unresolved. As we work together we will identify what past experiences are playing out for each of you now.”

I usually ask couples if they shared any of their sexual history discussions with each other. I was not surprised to hear that Harold and Martha had not and used that as an example about how little they communicate with each other especially about sexual feelings and experiences. I externalized the problem (White & Epston, 1990) by pointing out how neither of them witnessed open constructive communication in their families. Both learned about sex outside the home. I also shared how vulnerabilities were denied, Harold’s as it related to his mother’s (and his own) vulnerability to his father’s dominance, and Martha’s related to her parents’ preference for her sister.

I suggested that Harold and Martha ran their early sexual life like a successful business, efficient, predictable, and performance based, enjoyable at first but unsus-

tainable over the long haul. I asked them if they would be willing to experiment with other approaches to sex that are more pleasure- or connection-based so they could slow down and learn to communicate better with each other. They agreed. I prescribed a vacation from intercourse, which they laughed about since they had not attempted sex in almost a year. To reduce possible performance anxiety about our work, I described the (in)completion of assignments as a “win-win” experience wherein if they completed the assignment they would become more sexually connected and if they did not, we would have an opportunity to identify barriers to sexual intimacy.

Deconstructing Sex with the Sexual Menu

Part of co-creating new sexual experiences involves a process of deconstructing sex and increasing sexual communication. Many “sexless” relationships develop because the couple, like Harold and Martha, has a one-item sexual menu. If one partner does not want intercourse tonight, a sexual invitation gets turned down, and sometimes kissing and hugging stops. Imagine going to a restaurant and ordering the same meal every time. Imagine expecting you and your partner to want the same menu item or the same number of courses each time you dine out. Sometimes you are not hungry but go out to eat with your partner anyway because you want to be together.

Sex and food are often compared with each other. In psychotherapy the food analogy through the use of the sexual menu helps couples understand the need to be more specific and flexible about sexuality in a light-hearted way. It offers the couple a nonjudgmental way of expressing preferences while normalizing differences. One may prefer fast food (a quickie) one day and a leisurely meal (making love) next time. It encompasses the need to know what one wants, to express it clearly, and to negotiate differences. I get my way and have Italian food tonight, and then am willing to go for Chinese, your favorite, next week.

When I give the assignment I tell clients to go home and make separate lists of their own sexual menu items and not to share them with each other. I encourage them to make as expansive a list of erotic, sensual, and sexual items as possible, being aware not to censor themselves by labeling an item as too tame, kinky, or queer. Forget what their partner likes or dislikes. There are no “good or bad” or “right or wrong” menu items. Lists are neither too long nor too short and may be revised. I usually give examples of items that involve all of the senses like looking at a sunset or a partner’s body, reading erotica or listening to music, tastes or smells, physical activity or contact.

When I gave directions to Harold and Martha, I paved the way for Harold to raise his desire for nipple and anal play by casually mentioning them among other possible items. They returned the following week mentioning how just writing the list expanded their awareness about many pleasurable erotic activities beyond intercourse.

I asked each to share his/her list with no cross-talk. Given their lack of sexual communication, I normalized any embarrassment or awkwardness they might feel reading their lists out loud. I then invited them to discuss their reactions to each other’s list, being mindful to use noncritical language. Harold included both nipple and anal play on his list and seemed relieved that Martha seemed to have no particular antipathy toward them, something he never knew but feared. I knew this represented the beginning of a profound healing for Harold. Martha included relational items, like flirting and being picked up at a bar, which spoke to her need to feel desired again by

Harold. Neither felt surprised or uncomfortable with any of the items. Both welcomed the opportunity to learn more about each other. Use of the sexual menu helps partners work through the anxieties of knowing and being known, expressing and exploring wishes, wants, and fears, toward the goal of developing greater sexual relatedness. I told them that we would use the larger sexual menu to create future assignments but because they had not been sexually intimate for a while, we would start with touching.

Redesigning Sensate Focus as Mindfulness Meditation

When Masters and Johnson developed their approach to sex therapy, a key technique was sensate focus. They believed that a primary source of sexual dysfunction was *spectatoring*, which they defined as watching what one is doing instead of experiencing it. Sensate focus, progressive touching leading eventually to intercourse, emphasizes attending to physical sensation instead of one's thoughts. It is often prescribed to break the ice and set in motion a progressive process of physical engagement. Couples are initially instructed to take turns touching each other. Each week more erotic interaction is built in, touching breasts and genitals, oral-genital contact, moving toward penetration and intercourse.

For couples who are concerned about their sexual lives, ignoring the mind is not easy. Instructions to focus on sensation instead of observation usually end with clients feeling defeated. After years of sexual deprivation, frustration, performance anxiety, or failure, it seems impossible to rid the mind of its associations to past wounds or fearful outcomes. Distracting thoughts combined with concerns about "what's supposed to happen next" often cause clients to avoid the assignment or eventually lose interest as a defense.

Instead of attempting to banish it, I welcome the "observer" and frame it as an ally in helping each partner discover what distracts him/her during sexual engagement. I frame sensate focus as a sexual meditation practice whose goal is to increase sexual presence, comfort, and connection. Using meditation techniques (Hanh, 1990; Kabat-Zinn, 1994), I ask clients to become aware of their thoughts, feelings, and bodily sensations, as well as their breathing, while touching.

I instructed Harold and Martha to begin (nonerogenous zone) touching for only 5 minutes each and to use a timer instead of looking at a clock. They decided to start with clothes on. I asked each of them to purchase a sexual journal in which they were to write about their experiences after giving and receiving. I told them to refrain from sharing their writing or verbally processing the experience at home. Over the next few months they increased the time and removed more clothes.

Because the goal is the development of presence instead of the achievement of a particular physical act ("being" vs. "doing"), partners often relax sooner and become interested in the meaning and function of their inner "noise." As partners read and discuss their writing, they become aware of each other's feelings about giving and receiving, body image, reciprocity, and fears about intimacy and connection. Harold was surprised about how long it took him to settle down mentally. His chatter was greater when he received than gave which made sense since his lifelong sexual script was about being the dominant giver. He felt much more vulnerable as the receiver. Martha became aware that her fears of rejection were more present when she gave than received. She assumed that if Harold was giving to her, it meant that he desired her. Her fears even extended to initiating the assignment. Harold, as he did with sex,

usually initiated the assignment. These insights opened up a deeper discussion about how each of them struggled with different roles of desiring or being desired.

Over the next several weeks, Harold offered to tell Martha how much he wanted her when she gave so she could experience herself as desired in that role. Martha encouraged Harold to practice asking to have different body parts touched so he could feel safer receiving. It was very moving to see how Harold and Martha were beginning to become healers of each other's deepest wounds. By attending to distracting thoughts, Harold and Martha were able work through underlying issues and eventually the distractions subsided. They were beginning to be more in their bodies in more expansive ways. I believe the structure of this assignment, including time limits and writing, creates a safe container within which clients may explore their erotic potential.

As couples feel more competent they take ownership of the assignments (length, content, and frequency), eventually bringing a mindful presence and renewed passion to expansive sexual experiences. I knew Harold and Martha experienced a breakthrough when they came in, after including erogenous zones for a few weeks, and reported that Martha confidently initiated the assignment and Harold asked Martha to concentrate on his nipples. She loved giving him pleasure and he loved receiving it. He was fully aroused and expressed his desire for her. The healing was happening.

Queer Generational Differences

Harold serves as an example of someone at mid-life whose experience of queerness was confusing and disturbing, so much so that he withdrew from partnered sex to avoid it. In cases where queerness is ego-dystonic, the therapist's role is to help the client understand why and to provide information that normalizes diversity and fluidity of sex/gender experiences.

As a man in his 50s, Harold did not have the cultural exposure that younger people have today where sex and gender variability are more visible and normalized. Many high schools have gay/straight alliances to educate school personnel to prevent harassment of LGBT (gay, lesbian, bisexual, transgendered) students. Young adults have developed language to express more expansive sex/gender explorations such as: "bi-curious" (exploring same and other sex feelings), lesbian until graduation, or reappropriated words such as "queer" (eschewing gender/sex binaries). These cultural changes enter the therapy room in the diverse ways some younger clients describe identity, use language, or practice gender and sexual behavior.

Jim and Annie, a couple in their 20s, entered therapy to understand why sex was difficult during most of their 4-year relationship. They met in a Queer Studies class in college, becoming friends, political activists, and then lovers. After college they moved to New York and got married. They felt compatible intellectually, politically, emotionally, and spiritually. They were very much in love and wanted to start a family.

A few minutes into their first session, I experienced an amusing queer moment as they introduced themselves as Kinsey scores. Annie was a "Kinsey 4" and Jim was a "Kinsey 5" (on a scale where 0 = *represents heterosexual* and 6 = *represents homosexual*). They proceeded, without any prompting by me, to expand on what they said by clarifying that those scores pertained only to their sexual behavior. They were sexually attracted to men and women equally and fantasized about both when masturbating. Annie had fallen in love with most of the men and women she dated. Jim

had only been in love with men before he met Annie. Their detailed renditions of the complexity of their sexual orientations seemed as if they were reading KSOG scores out loud. But they were not. Describing themselves as a “heterosexual queer couple,” they lived and discussed this complexity in a matter-of-fact way.

Their goal in therapy was to understand why sex was difficult for them from the beginning. They described sex as awkward, sometimes consisting of power struggles over who controlled what happened. They kissed, touched, performed oral sex, and had intercourse. Jim was upset that Annie could not orgasm with intercourse. It was not an issue for her. Annie embraced a pleasure-based model of sexual response. Jim was performance-based and felt that the reason Annie did not orgasm was because she was not really turned-on by him. His waning interest in sex was because he was disappointed that they did not both achieve orgasm during intercourse. They wanted to understand whether their problem was due to their sexual orientations (perhaps they should be with members of the same sex) or to another issue they did not yet know. I told them there might be other hypotheses but that I did need to conduct in-depth sexual histories first.

What were most striking about their histories were their sexual preferences with members of the same sex. Annie preferred being the top in strap-on sex with her female partners. She enjoyed the power and the pleasure, often reaching orgasm while observing her partner’s excitement. Jim’s favorite sexual activity was receptive anal sex, a role he experienced as very active. He loved being seductive and taken. His excitement peaked as he saw his partner’s desire wanting to “do” him. After completing the histories I became curious about why Annie and Jim were not indulging in their preferred sexual activities with each other.

When we met together, I told them I was surprised to learn about their past sexual preferences given their present sexual menu. They were intrigued and wondered aloud about why they restricted their menu items. Was it because they wanted to have kids? Or, were they playing out some unconscious vestiges of internalized heterosexism? Were they unwittingly reenacting gendered power dynamics internalized from their parents’ relationships?

I asked them how open they would be to add strap-on anal sex to their menu. They were willing, admitting that they did have to practice some. As they did, they were relieved to find greater ease and pleasure than they thought possible. Oddly, even though they had queer identities, it did not occur to them to have queerer sex.

The Therapist as Sexual Agent

The therapist plays many roles when working with the queerness of sex. They include: co-creator of safety, interviewer, sex educator, sexual detective, empathic listener, co-meaning-maker, hypothesis generator, coach, witness, sex-affirmative parent, and assignment-giving teacher. All contain unique transferences and counter-transferences for couples and therapists. Some of the roles may feel awkward depending on the primary training of the therapist. Feeling adequately knowledgeable and skilled takes time. Then along comes a queer moment to disrupt the calm.

More importantly, therapists need to appreciate how powerful a role their own experiences, values, and biases play in the sexual therapeutic arena. What sexual response cycle does the therapist endorse? What constitutes good enough sex in treatment or in life? How easy is it to consider “successful” a completed therapy in

which the couple is not having any more sex but feels closer than ever? How do we deal with the inherent contradictions and paradoxes of erotic life? How willing are we to expose ourselves to sexual material, especially the disturbing kind, for the sake of discovering our sexual edges? It is, indeed, queer work. We can best handle the challenge by taking Stephen Mitchell's (2002) advice about how to make romance last over time, "the cultivation of romance in relationships requires two people who are fascinated by the ways in which, individually and together, they generate forms of life they can count on . . . [while developing] . . . a tolerance of the fragility of those hopes" (p. 201).

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