Sexual problems and LGBT people

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Shared experience and assumptions

- Impact of homo/bi/trans phobia, plus wider cultural attitudes to masculinity, femininity and sexuality have a large impact on identity/sexual self
- HIV disproportionately affects the sexual lives of the MSM and trans community
- Research into sexual function for LGBT population often not generalisable or inherently flawed.
- Standards of ‘normality’ re sexual function are often based on hetero/cis/male perspectives
- Institutions, medics, clinicians and therapists all influenced by and perpetuate ignorance or discrimination
Opportunities for LGBT people in their sexual lives

• Not socialised into a model of what sex should look like
• Sex can be more egalitarian/reciprocal and less defined roles during sex
• Wider focus on what constitutes ‘sex’ than hetero (Sewell et al 2016)
• More open to using sex toys and lube (Reece et al, 2010)
• More open to diverse relationship structures

• Opportunities for more sexual freedom, increased sexual novelty, more flexibility to work round sexual problems, diversity of sexual experience and satisfaction
Case study

• Alex (29) and Remi (34) have been together for 8 years. They have presented to your service for concerns around the dwindling of their sexual activity together over the last 5 years. They are both keen for things to change as they feel concerned about the future longevity of their relationship.
Case study- MSM

• Alex and Remi are MSM, and Remi is HIV positive and undetectable. They tell you that part of the solution they have stumbled upon is to have chemsex with each other and others at parties as they notice that the problem isn’t around as much then. They are enjoying this but are starting to notice negative effects of it on their life and relationship. They have both got into trouble at work for sick days, are doing chems one weekend in two for 3 days at a time, and feel that sex together without chems would be an impossibility.

• How might we understand this from a biopsychosocial perspective? What might we do?
MSM

- HIV an independent risk factor for ED (Shindel et al, 2012)
- Impact of depression and SSRIs on sexual functioning (Purcell et al, 2005)
- Impact of chemsex on sexual functioning and difficulty with sober sex
- Anodyspareunia - similar prevalence as pain during vaginal sex (Damon & Rosser, 2005)
- MSM are more likely to report greater extremes of sexual desire in response to depressed or anxious mood (Bancroft et al 2003)
Alex and Remi as MSM – what do we do?

• Normalise their experience of sex in a LT rel’ship
• Allow them space to reflect on pros and cons of relationship structure
• Discuss the meaning of the reduction of desire and the intersection of this with sexuality and gender
• Understand the impact of HIV and low mood on desire and sexual functioning
• Consider the role of community and culture on discourses of sex
• Consider the impact of chems on sober sex (kickstarting desire, pleasure, sexual identity, community, accessibility, attentional focus)

• Work may involve, enabling decisions about chems/re’ship structure moving forward, scheduling, increasing ‘good enough’/accessible sex, normalising distraction and mindfulness.
Case study

• Alex and Remi are WSW, and both in good health. They live together and are planning a long term future together. Remi has been in a previous relationship where the same thing happened, and she and this other partner stopped having sex for a few years then eventually broke up. She is terrified of this happening again. Both of them joke with you in the first session ‘you know what lesbians are like’

• How might we understand this from a biopsychosocial perspective? What might we do?
WSW

- Low desire only sexual problem consistently reported (Nichols, 2014), but given that all women report a diminished desire in LT relationships (Cohen & Byers, 2014) loses meaning.
- Caused by ‘inadequate heterocentric/phallocentric conceptualisations of what constitutes sex or good sex’ (Diamond 2008).
- Traditional methods used in research omitting of lots of behaviours WSW define as sex, and counting sexual frequency as the sole marker of good sex.
- Couples may present worrying about ‘lesbian bed death’ and interpret as problematic.
- WSW report greater satisfaction than WSM including greater arousal, more orgasms, and longer and more varied sex sessions. ‘Orgasm gap’ less prevalent in WSW (Hetero women 65% ’usually or always reach orgasm, compared with 86% WSW, Frederick et al, 2017).
Alex and Remi as WSW– what do we do?

• Normalise their experience of changes in desire in a LT rel’ship
• Do nothing? Psychoed only?
• Discuss the meaning of the perceived change in desire and the intersection of this with sexuality and gender
• Challenge negative stereotypes around WSW and sex
• Psychoed re: models of desire (Basson), how scheduling may be especially useful in WSW and use Sex Therapy to implement this if still needed
Case study

- Alex is a cis gendered lesbian, and Remi is a transman, who is taking hormones. Since Remi started to socially transition 3 years ago, Alex felt that their sex life became inaccessible. Remi desperately wants to stay in the relationship as he loves Alex, but says ‘I just don’t know how to be with her as the real me.’

- How might we understand this from a biopsychosocial perspective? What might we do?
Trans men and women

• Gender Dysphoria – discomfort and distress between sex assigned at birth and gender identity (Richards and Barker 2013)
• Some trans people high levels of dysphoria around their genitals and touch can be triggering, others minimal and can affect sexual functioning
• Discomfort can lead to less/avoidance of masturbation (Erickson-Schroth, 2014) or over focus on partner as a coping strategy
• This might change as a result of transition
• Sexual problems in the couple can be related to this or a change in sexual preferences or orientation
• Historically lack of research done to not by the community. Crucial PHE paper out next year
  – Large proportion fear not being perceived as their gender during sex
  – High levels of distress
Remi as a Trans man – what do we do?

- Is the change anything to do with Remi identifying as trans?
- Understanding the impact of internalised transnegativity or dysphoria on sex life to date
- Mapping how Remi experiences their body sexually
- Working on body confidence
- Understanding how past coping mechanisms may now not be working
- Masturbation as a vehicle for understanding functionality and decreasing dysphoria, new techniques and language
- Supporting them both with change in the sexual relationship and orientation for Alex (and Remi) which may (or may not) means new sexual practices.
Take home messages

• Socio-Psycho-Bio model?
• ‘Sex therapy is politics’ (Tiefer)
• **Affirmative stance** essential to take into account the particular contexts affecting these groups to avoid pathologising and work ethically.
• Clinicians can **take an active role in counteracting pervasive negative messages** of devaluation of LGBT people
• Therapists values around gender, non conformity and sexuality impact therapeutic outcomes (Vasquez, 2007). (Displayed by attention to language, attention to assumptions, attention to our own cultural competence, beliefs and values)