

Sex and Relationship Issues in Work With the LGBTQ Community

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Working with LGBTQ people regarding sex and relationship problems may be intimidating for the psychiatrist with little experience. This article provides an overview of common sex and relationship problems that can be encountered in clinical work with a focus on LGBTQ couples therapy. Topics include sex difficulties and their causes,

drugs and alcohol, the effect of “the closet,” discordant “outness” in couples, issues regarding sex roles, LGBTQ parenting, and issues arising when a member of a couple is transitioning.

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In this article, although it is limited in scope, the acronym LGBTQ—standing for lesbian, gay, bisexual, transgender, and queer—is used to connote a comprehensive group of sexual and gender minorities, including, but not limited to, the aforementioned identities. As LGBTQ individuals are increasingly accepted in the larger community (1), many of the sexual and relationship issues facing LGBTQ couples become indistinguishable from those facing all couples. However, there are enough experiences unique to LGBTQ people to make a greater understanding of some of their issues essential to anyone working with sexual and relationship challenges in members of this population. Many books and edited volumes have been written about working with LGBTQ patients in general (2–4) and about working with LGBTQ relationships in particular (5–8). This article is meant to serve as a starting place for psychiatrists and other mental health professionals who have little experience in working with members of the LGBTQ community who are struggling with issues of sexuality and relationships.

BACKGROUND

Although identifying as LGBTQ can happen at any point during a person’s development, an LGBTQ identity may not be fully accepted until long after a same-sex sexual attraction or gender incongruence is first recognized (9). Because much of the world is not a friendly place for LGBTQ people, it may be traumatic to discover that one might be LGBTQ and therefore seen as deviant or sinful—or even engaging in unlawful activity. Early in development, LGBTQ people can be taught that their fantasies and desires are “wrong” and,

until recently, that they should be changed or “repaired” (10). They have often been taught throughout life that what they do sexually is “unnatural,” and this can have a lasting effect on their self-esteem.

A therapist who is inexperienced in working with LGBTQ patients should maintain awareness of her or his biases, countertransference feelings, and reactions. Although no therapist comes to their work intending to judge their patients or induce shame, inadvertent behaviors, (e.g., avoidance of subjects related to sex or expressing outdated opinions or stereotypes) can disrupt a therapeutic alliance and fumble a key opportunity for the patient to experience a nonjudgmental space. If a therapist is unable to accept the LGBTQ identity of a patient or couple, whether on religious grounds or other bias, we believe that it is that therapist’s responsibility to disclose this from the outset and offer the patient or couple the option of working with a different therapist.

LGBTQ therapists can themselves have unexamined or unconscious bias in the form of internalized homophobia and are not immune to making assumption and judgments about their LGBTQ patients. The issue of self-disclosure of sexual orientation by the therapist was more controversial in the past and was a subject first taken up by Richard Isay, M.D., in his 1989 book, *Being Homosexual*. Isay advocated for self-disclosure to patients of a similar LGBTQ status to destigmatize the identity, suggesting that being circumspect perpetuated shame, whereas being open provided a healthy role model for patients. This ran counter to the then-general tendency, following classical psychoanalytic tradition, to remain as anonymous as possible to one’s patients. It is our

opinion that, as psychoanalysis has evolved in the direction of greater openness, this has become less of a controversy, favoring judicious and reflective use of self-disclosure as appropriate.

In some parts of the world, acts labeled as “homosexual” are against the law and can lead to imprisonment or death. These and other factors can lead LGBTQ people to conceal their sexual orientation or gender identity from the people around them. This is referred to as being “in the closet” (11).

Many LGBTQ people may delay exploring sex and sexuality because of societal discouragement from following their natural impulses. LGBTQ individuals may also find themselves facing the milestones of dating and forming relationships at a later age than their non-LGBTQ peers, and not receiving the social and family support or developmental modeling that these peers received. This includes traditional developmental rituals, such as proms and the support of adolescent peer groups. LGBTQ people struggling with learning how to form relationships may even find themselves undermined by family members who are unwilling to accept their LGBTQ identity and who condemn their relationships.

LGBTQ people also did not, until recently, have healthy role models of sexual behavior. A young gay man might only witness intimacy between two men in pornography. The act of people of the same sex kissing, embracing, or holding hands had rarely been seen in media in the United States until 1991 (12). Even now, portrayals of gay and lesbian intimacy in the media are often used for comedic effect or reinforce inaccurate stereotypes and carry with them a weight of shame. The shame one associates with sex can result in problems with emotional and physical intimacy within LGBTQ relationships. Whereas many heterosexual people might chalk up sex problems to typical life stressors, LGBTQ people might assign blame to their identity. They might believe that the reason they experience sex-related concerns is not because of common relational concerns but because they are LGBTQ.

TREATING SEXUAL PROBLEMS

Many LGBTQ people have turned their sexual diversity into a source of pride and freedom. Not having healthy role models for sex creates a blank canvas for LGBTQ people to discover what they find sexually pleasing, both about their own bodies and those of their partners. Clinicians working with individuals and couples regarding their sex lives can find a sex-positive stance useful in helping patients enjoy that aspect of their lives. Mental health clinicians need to be knowledgeable and ready to talk about sex in the context of LGBTQ relationships. LGBTQ couples may need specialized guidance in sex therapy. Although many books and articles regarding sex therapy exist, few (e.g., 13–15) are tailored to the needs of LGBTQ people. With professional assistance, LGBTQ individuals and couples with sexual challenges can learn to enjoy positive sexual relationships and skills that will strengthen those relationships.

Sex among LGBTQ people is as diverse as the people the name represents. Aside from the pioneering research of Alfred Kinsey and colleagues (16), with the addition of the work of Masters and Johnson (17), little is still known about what people—regardless of sexual orientation or gender identity—do in the bedroom. The word “sex” itself is vague and could imply numerous things, from kissing to mutual masturbation, to water sports (urine play), to anal penetrative sex. It is helpful to pay less attention to the word “sex” and use the word as an opportunity to ask more detailed questions about what it means for each individual patient. However, one challenge that many clinicians have is contending with their own personal beliefs about what constitutes a healthy sex life. One’s own views of sexuality and how one thinks sex is “supposed to look” can interfere with one’s ability to provide affirming and therapeutic interventions with patients.

Relationships have traditionally been represented in the media as being between a man and a woman. When LGBTQ people look for models of how to behave sexually with a partner, they have no guidance from families and the wider world. They may take what they know about the cisgender, heterosexual world and apply it to themselves, possibly leading to self-judgment and sexual dysfunction. In addressing that lack of knowledge, much of what a clinician can do to be therapeutic is help a patient discover what excites them sexually and involves sexual consent but, nevertheless, may encourage alternatives to stereotypical norms. From the perspective of understanding masculine and feminine, male and female, dominant and submissive, and top and bottom as social constructs, these terms may become less meaningful to the general population as time progresses.

Whereas many individuals might go to a primary health care professional to discuss sexual concerns, LGBTQ people may only feel comfortable discussing sex and sexuality with someone they trust and whom they believe will not stigmatize their identity. Given the sensitive nature of the topic, particularly with some transgender and gender-nonbinary people, sexual concerns may not arise until years into therapy when the patient becomes more comfortable with their doctor-patient relationship. A therapist’s ability to listen and to be open about discussing all sexual matters without judgment can go a long way in gaining the patient’s openness and trust.

Steven and Adam are two gay men in their late 20s who are forming a new relationship. They have been on several dates and are starting to experience each other sexually. They both come from households of “traditional families.” Both of their fathers worked blue-collar jobs, and their mothers were homemakers. Both have been out of the closet for a year, and dating men is a relatively new experience.

On the night of their first sexual experience, both were intoxicated as they attempted anal intercourse. Later, when interviewed individually, both disclosed to the therapist a desire to be “versatile”—that is, both insertive and receptive—but both felt it necessary to start the relationship

off in the role of “top” or insertive partner. Despite his misgivings, Adam decided to try and “bottom”—that is, be the receptive partner—for Steven.

Given their inexperience, experimenting with anal sex did not go well for either of them. Steven was unable to penetrate Adam and blamed himself for this “failure.” He worried he wasn’t “manly enough” to have sex “the right way.” Adam also felt shame, thinking he wasn’t “cut out to be a gay man” because he was unable to bottom as he was “too tight.” During sex, he kept thinking about how his parents would be aghast at what he was doing and found it difficult to relax. Neither of them disclosed this information to the other out of fear that doing so would end their blossoming relationship. On the other hand, they want to stay together because they enjoy each other’s company very much, which is why they decided to seek couples treatment.

Given that sexual relationships among LGBTQ people in the past (and, in many parts of the world, the present) were seen as deviant and even criminal, it is not difficult to imagine that challenges to sexuality can be related to many factors, both psychological and physiological. Whereas cisgender heterosexual patients rarely blame their sexual or gender identity as the cause of their symptoms, some LGBTQ people, because of internalized homophobia and transphobia, may believe that their identity is the cause of their sexual problems. In such cases, it is helpful for clinicians to provide appropriate psychoeducation to help destigmatize sexually diverse activities and interests.

The case of Steven and Adam illustrates how layering of social and individual beliefs can impede a positive sexual experience. Steven and Adam were making their decisions and sexual behaviors based on socially assigned roles that they had internalized. They were only partially honest with themselves about what they wanted, and it seems that neither was forthcoming with the other about their sexual preferences or experience.

It is possible that if Steven and Adam had access to media representations conveying male-male sexual relationship discussions, or even if they had spoken with their friends, they may have been better prepared to set boundaries and make decisions about how they wanted to explore sex with each other. Adam, for instance, inexperienced at bottoming, blamed himself for his inability to perform instead of realizing that each person has their own physiological and psychological reactions to the role. Any sexual concern or dysfunction in the LGBTQ population is best evaluated in the context of each person’s own sexual belief system, identity, and experience. A therapist could assist Steven and Adam by exploring their beliefs and perceptions about sex and sexuality. The couple may not be aware that specifics around sex are topics often covered in therapy. It is possible that many patients still believe it is inappropriate to bring up sex in a professional therapeutic setting.

Juliet is a 29-year-old woman of transgender experience. She was assigned male at birth and started a social transition during her college years. She has had top surgery (breast

implants) but has decided not to have bottom (genital) surgery at the present time, because she enjoys using her penis during sexual activity. Juliet only feels comfortable engaging in sexual activity with other transgender women because of a history of sexual trauma. She has engaged in various forms of sexual intercourse, including insertive penile-vaginal intercourse with transgender women who have had vaginoplasty.

Juliet reports to her psychiatrist that she has been having problems maintaining an erection. She thinks this might be a sign that she should have a vaginoplasty and that all transgender women should have bottom surgery. When discussing the topic in more detail, Juliet knows that she doesn’t believe this logically but says it’s a feeling that lingers in the back of her mind.

Juliet’s case raises many questions about what could cause the erectile dysfunction she is experiencing. A therapist could further inquire about the thoughts going through her mind during her sexual activity, perhaps providing some insight into how internalized transphobia might be factoring into her symptoms. Transphobia represents negative views about transgender people, and, specifically, internalized transphobia reflects negative views that transgender people may have internalized from the culture and hold about themselves. By discussing her thoughts and actions in detail, her psychiatrist gained access to some of her core beliefs and provided a healing intervention to affirm both her gender identity and sexual identity.

Hypothetically, however, other factors might contribute to the erectile dysfunction she is reporting. A history of sexual trauma could have lingering effects on Juliet’s sex life. If safety has been established adequately in the therapeutic relationship, it might be useful to further explore the effect that this trauma history is having on her present-day life.

Feminizing hormones might also play a role in Juliet’s symptoms; she may be on estrogen therapy as well as a testosterone blocker. The standard doses of both hormones prescribed to transgender women can affect erectile function. Ideally, this was discussed by her prescriber during the informed-consent portion of hormone initiation, but she might not remember. Discussing the possibilities that hormones could be a factor might provide an avenue for treatment as simple as changing the dose. However, the patient may also be comforted to know that there may be a biological, rather than a psychological, cause for her symptoms.

DRUGS AND ALCOHOL

There is a long association between LGBTQ people and alcohol, as gay bars were historically a primary location for socializing and finding potential partners. Over time, drugs such as amyl nitrate, cocaine, ecstasy, and crystal methamphetamine became prevalent in some LGBTQ communities, potentially causing psychological and physical damage. Some report that they can use these drugs in small amounts responsibly, but with a lack of government regulation, it is impossible to know exactly what is in a given substance (18). Drugs can become so

intertwined in a person's sexual life that they are unable to experience sexual pleasure without the presence of a particular substance. Furthermore, whereas some LGBTQ individuals may identify the dissociative experience of using a drug as a potential step into sexual freedom, others may consider it a veil of suppression for those with internalized stigma.

Michael is a 25-year-old gay man who initially comes to treatment for symptoms of generalized anxiety, which improved with the use of medication and psychotherapy. During a session, he mentions that his new boyfriend has been annoyed with him lately because Michael consistently uses poppers, or amyl nitrate, during sex. Upon questioning, his doctor learns that Michael started using poppers several years ago when he was first coming out and exploring the gay bar scene. The sensation they provided helped him relax in a crowded club environment.

Because he preferred to bottom, he felt that it had a positive effect on his sex life, and he developed the habit of using poppers every time he had sex. Michael's boyfriend now feels like it is a problem, saying that if Michael really loved him, he wouldn't need poppers anymore.

Amyl nitrate is used by some gay men because of the mild dissociating effects and smooth muscle relaxation, particularly of the anal sphincter, making it easier to engage in receptive anal intercourse. This may be a physiological reason why Michael believes that he needs poppers to have anal sex. However, it might also be more of a habit at this point, and Michael is afraid of exploring sex without a substance that he has become accustomed to using. Further exploration, including helping Michael's boyfriend explore his projections onto Michael's reliance on poppers, is necessary to help this couple.

WORKING WITH COUPLES

LGBTQ people whose families and religious institutions may not support their unions and who, until recently, did not have the privileges of legal sanction and protection of their partnerships, have to wrestle with an internalized belief that their relationship is illegitimate. When their relationship is challenged by conflict, they may not receive the emotional support, advice, and encouragement of family members and clergy to help make their relationship work. A therapist working with such a couple may be the first person to ever tell them that their relationship is worth fighting for.

Most of the principles guiding couples therapy in general apply to couples therapy with LGBTQ partners, but there are key differences resulting from the effects of being members of a marginalized group who are discriminated against. Some of these differences include the following:

- the closet and its developmental effect on LGBTQ people's comfort with intimacy and ability to be emotionally open and vulnerable
- discordance within the relationship about who is in and who is out of the closet
- nontraditional gender roles in LGBTQ relationships

- historic legal denial of marriage to LGBTQ couples
- greater variability of non-monogamy in LGBTQ relationships
- the possibility of a gender transition during a relationship and
- greater complexity about parenting.

The effects of some of these differences are illustrated in the following clinical vignettes. Please note that these vignettes are included to highlight issues unique to working with LGBTQ couples and not to suggest comprehensive treatments or outcomes. To avoid blind spots and other countertransferences while treating LGBTQ couples, one must be aware of one's own possible biases and stereotypical ideas about them. It is also helpful to pay attention to how one's LGBTQ patients may hold similar stereotypes.

EFFECTS OF THE CLOSET ON RELATIONSHIPS

The efforts that LGBTQ people make to conceal their identity (11) may shape their personality in ways that inhibit open expression of emotion and vulnerability. This can create challenges when they are later attempting to participate in an intimate relationship. Essential early goals in working with LGBTQ relationships include helping patients recognize their shame, particularly about their emotions; helping their partners be understanding and supportive about this struggle; and helping both members of a couple recognize how difficult it can be to show their emotions openly and honestly and how important this is for effective communication.

DISCORDANT OUTNESS

Bill, who grew up in a liberal, urban environment, is hurt and angered that Ted, who grew up in a community less welcoming of LGBTQ people, leaves Bill behind during every holiday visit to his hometown. Ted also tells his friends and family that he is single and "just hasn't met the right girl yet." Once, when Ted's parents came to visit, Ted insisted that Bill stay with a friend rather than in their one-bedroom apartment. Ted "straightened up the apartment" by hiding every picture of the two of them and any sign that Bill existed in Ted's life. Ted is upset, feeling that Bill doesn't appreciate how frightened he is of losing his connection to his family, whom he loves dearly despite their socially conservative values. Bill believes, "If they can't accept you for who you are, you are no worse off without them." He also believes that Ted's fears reflect shame about who he is and feels offended by what he considers Ted judging himself, Bill, and their relationship.

One effect of the closet can be seen when one member of the couple is out and the other member is not. The closeted individual, who likely faces a great deal of shame about their identity and about the relationship itself, may not be willing to include their partner in personal, professional, and family engagements; acknowledge their partner's existence; or, when the couple is in the company of a third party, acknowledge the nature of their relationship. The excluded partner often finds

this hurtful and may experience the kind of shame they previously spent much time and energy to overcome.

This is a common source of conflict in such couples for which there is no singular solution. Sometimes an individual may remain closeted to manage long-standing shame and possible associated trauma. In such a case, helping that person overcome their shame and come out of the closet may be beneficial. At other times, coming out could result in loss of employment or important family relationships. In that case, it might be more helpful to assist the partner who is more out to develop compassion and understanding of the closeted partner's challenges without taking their decisions personally.

GENDER ROLES

Nick and Joe, both 22 years old, are accepted by their working-class families. However, both have very traditional and sexist ideas about masculinity. Having just moved in together, they have had ongoing fights because fastidious Nick can't bear the mess that Joe leaves; yet he bristles every time Joe says, "You want it clean, you clean it!" He hears a gendered meaning behind Joe's demands which is that he, Nick, is the "sissy girl" in the relationship and that the chores of cleaning are his "female" responsibility.

Most couples therapists are familiar with conflicts over traditional gender roles in a heterosexual relationship, particularly with respect to household labor or earning potential. These issues also arise in gay male and lesbian couples. One reason often stems from internalized homophobia, including internalized shame about gender expression and gender role. The prospect of taking on a household role that challenges one's masculinity or femininity can be a source of shame for one or both members of a couple. This may result in competitiveness, difficulty with compromise, or both. In couples where one or both partners are transgender, there may be similar or even more marked challenges in managing gender role expectations in the relationship.

Another important couples therapy theme that can be colored by gender role expectations is income disparity:

Bob and Michael are both accountants who met in graduate school. While Bob was content with a small private practice, he made use of some of his connections to help Michael get a job in a major accounting firm where his career soared. As a result, his income also increased. Although Bob appreciated the benefits of this income for them as a couple, he also felt shame and even some resentment. He began referring to his income as a "rounding error" in relationship to Michael's income and even began questioning Michael's commitment to the relationship. He even wondered whether he could have been the bigger earner if he had only used his connections for himself.

One challenge to same-sex couples can result from pre-existing disparities in income or from sudden changes, either an increase or a decrease, of one member's income. Sometimes, a couple must decide to make sacrifices in one member's career or the couple's lifestyle for the sake of the geographic

location of a partner's job or for child rearing. When such sacrifices tap into issues of self-esteem, to which one or both members of the couple were already vulnerable, this can be especially challenging.

LGBTQ MARRIAGE

Martha and Ramona had been together for 30 years when marriage became a legal option for them. However, having been denied legal sanction for so long, they rejected the idea of marrying when they finally could. They saw no benefit for them, since they were both retired, both were on Medicare, and both had modest savings and no children. This changed when Martha's aunt died, bequeathing her a considerable inheritance. Concerned that Martha's homophobic family would contest her own will, they decided to marry.

Martha, who saw marriage as a legal expedient, wanted a quick legal ceremony with just one witness, whereas Ramona wanted to finally have the large and showy wedding she had secretly wished for all her life. Martha was offended by Ramona's sudden intense interest in an institution she politically rejected as both heterosexist and sexist. She was also not prepared to spend such a large amount of the money they had just inherited. They presented to couples therapy because, while Ramona now wanted desperately to marry, Martha was not even sure she wanted to stay in the relationship.

One of the many challenges to LGBTQ relationships has been the absence of any legal support for them. This changed in the United States on a national level as a result of the Supreme court decision in the case of *Obergefell v. Hodges* (19). This newly available option to marry for gay and lesbian couples has introduced its own sets of challenges. Some LGBTQ partners formed relationships long ago that did not conform to the social standards of heterosexual relationships; for example, "open" or nonmonogamous relationships, relationships with three or more members (polyamory), and relationships in which partners opted not to live in the same residence or in which partners only lived together part time. Some of these couples continue to reject marriage. Other couples, who have had long-standing relationships, such as Martha and Ramona, suddenly recognize challenges and obstacles that were only highlighted when marriage became an option. Such couples may benefit from validation, by their therapist, that their relationship of many years is not exclusively legitimized by marriage. Planning a wedding may force previously unnoticed difficulties with negotiating or compromise to the surface. There may be challenges that arise from the legalities of marriage that may erase previous ways the couple had negotiated finances, assets, parenting, or inheritance. These issues may benefit from therapy before or after the couple has wed.

For some in the LGBTQ community, identifying as queer can be particularly relevant to the aforementioned issues. The connotation of "queer" is antiestablishment and resonates with a cherishing of the "outsider" aspects of being LGBTQ (20). Individuals with such an identity may

politically oppose marriage, believing it to be an outdated institution or a tool of social oppression. This may create a conflict with a partner who may not share similar views. One possible way of bridging a divide of this nature in therapy is to encourage the couple to mutually consider ways of “queering” a marriage ceremony; that is, identifying any elements that are objectionable and putting their own reconstructed spin on them. A nonmonogamous couple may leave the words “forsaking all others” out of their vows. One couple, in lieu of having an organist, hired an LGBTQ marching band to perform the music at their wedding.

The absence of models for LGBTQ relationships has resulted in many couples making their own rules and approaches to their relationship. This may, of course, be true in a more traditional heterosexual couple as well. In either case, it is helpful to avoid assumptions about how the relationship works or “should” work in forming an alliance with the couple and helping them overcome the challenges that led them to seek help in the first place.

OPEN RELATIONSHIPS

44-year-old Scott and 52-year-old Frank are coming for couples therapy because they have found that the decision to open their 10-year, previously monogamous relationship is more complicated than they first expected. Frank’s waning libido was a partial factor in that decision, and so it has surprised both partners to find that Frank has become the more popular of the two on the dating apps, especially with much younger men. Scott is trying to manage his feelings of jealousy and regret about the decision, given that he was the one who initially pushed for the open arrangement. “Can we put the genie back in the bottle?” Scott wonders. Can they renegotiate boundaries after the fact?

Partners’ expectations of their relationship, if it changes to an open or other polyamorous arrangement, can be completely upended. If a couple has come for therapy in advance of making changes, the therapist can help with planning for contingencies and future recalibrating. Coming to therapy after the fact may require processing previously unexamined emotional effects before looking at renegotiating any structures. The essentially egalitarian nature of couples therapy, where the therapist actively works to ensure that both members of the couple are getting their needs addressed, may be particularly helpful in a situation like the aforementioned case where the power dynamics in the relationship are shifting.

POLYAMOROUS RELATIONSHIPS

Ten years into their sexually open relationship, Brenda and Evelyn faced a challenge. Brenda started having feelings for Karen, a woman with whom she had had, with Evelyn’s consent, multiple sexual encounters. Brenda introduced Evelyn to Karen; not only did they get along well, but when Brenda broached the subject, Evelyn was agreeable to adding

Karen to their relationship, and they became a “throuple.” Ten years later, when Karen’s work required a lot of travel, Brenda and Evelyn started having sex with Kris. They felt comfortable with the fact that they had previously navigated intimacy with a third (Karen) and, consequently, did not expect any problems. Evelyn, however, recognizing a growing closeness between Brenda and Kris, was becoming jealous. However, Brenda insisted that there was no basis for jealousy. She found Evelyn’s growing pressure on her to end the relationship with Kris unbearable. Brenda was now considering ending her 20-year relationship with Evelyn.

Distinct from “open” relationships, in which the couple allows for sex with other people, are polyamorous relationships in which love and intimacy with others are permitted. Such relationships take many forms and often, as with Brenda and Evelyn, begin as an open relationship. Usually, one member of the couple starts to have feelings for a third person. If these feelings do not distract from their love and commitment to the first person with whom they have coupled, and if all parties are amenable, a polyamorous relationship forms. Clinical work with polyamorous couples (e.g., “throuples” or “quadrouples”) can be complicated and may resemble family therapy. This subject could easily be a paper in and of itself, but some basic principles are addressed here.

First and foremost, when LGBTQ people approach a therapist for assistance with their relationship, they are already vulnerable, perhaps ashamed that they cannot “solve their own problems.” Additionally, being part of a culture that privileges monogamy, they may have their own complicated feelings about the relationship they have formed. In fact, they may be out of the closet about being LGBTQ but not yet out of the closet about being polyamorous. Therefore, it is important that a relationship therapist make efforts to understand how this group first came about; its explicit rules and hierarchy; and its members’ implicit beliefs, dynamics, and enactments.

As in the case of Evelyn and Brenda, it is important to be aware that jealousy is often a component of the challenges to the agreed-upon hierarchy and alliances within the group. A couples therapist can help jealous members of a polyamorous group acknowledge and accept these feelings. They may also help challenge their irrational basis. The therapist may help them express their feelings effectively within the family and negotiate their needs being met within the group.

As with any couple or family, a central challenge is helping the members recognize and navigate the complex dynamics that play out in their everyday lives. This can facilitate open expression of needs rather than acting out by using manipulation and indirect communication to get needs met.

A therapist can help members of a polyamorous family figure out how they wish to operate, what the hierarchy should look like, how to negotiate and renegotiate the hierarchy and structure(s) of the relationship(s), and how to negotiate getting their needs met within the agreed-upon hierarchy.

COUPLES IN GENDER TRANSITION

22-year-old TJ has been in a relationship with 25-year-old Ellen for a year. It has been going well, with Ellen being supportive of TJ's gradual steps in a transgender masculine identification. TJ goes by their initials rather than their highly feminine given name, Tiffany; adopts masculine dress; and uses the nonbinary pronouns "they/them." However, the couple is now coming for therapy because TJ wants to take testosterone.

Ellen, who is cisgender and identifies as a lesbian, feels conflicted. She loves TJ and wants to support them as best she can. However, she is aware of the highly masculinizing changes to be expected with testosterone therapy, many of them permanent. She realizes that such changes will affect how she sees TJ, especially in the context of sexual attraction, as well as how others will see them as a couple.

After experiencing much personal loss during her own coming out, with rejection and shaming from significant family members, Ellen has adopted a prideful stance in her lesbian sexual identity. How will she reconcile this with being seen as an ostensibly "straight" couple by others after TJ's transition on hormones? TJ, on the other hand, feels that taking testosterone will be the right choice for them personally. However, they are also concerned about how it will affect the couple, who are having the most meaningful romantic relationship thus far in their lifetime.

Transgender people sometimes start out in a lesbian or gay relationship as an interim step, on the way to fully understanding or accepting their transgender identity. They may first identify to themselves and others as LGB. Alternatively, they may have denied their difference altogether and ended up in a heterosexual relationship in which they are closeted to their partner. When their transgender status emerges within the couple, either in the course of couples therapy or before the couple commences treatment, the first challenge is helping them figure out if their relationship is still viable. Often, as in the case of TJ and Ellen, it is.

Then, much of the work of therapy involves helping the cisgender partner come to terms with the emerging identity and gender identity of their significant other. The cisgender individual also finds themselves having to come to terms with a shift in how their own sexual identity may appear to others. For example, a heterosexually identified woman whose husband comes out as a trans woman, now faces the prospect of being seen by others as a lesbian and may have to consider engaging in sexual activity she had not previously imagined. Such couples, when working well together, may have a very rich, diverse, and creative set of approaches to subsequent sex within the relationship.

In what was once a gay or lesbian relationship, transition may stir up shame in the transgender individual who, previously closeted about their gender identity, may have avoided revealing this. As their partner transitions, the cisgender LGB partner may have to revisit shame they had previously come to terms with as a member of a lesbian or gay couple while also coping with the complex reactions of

others to the changing nature of their relationship. A heterosexual, cisgender partner of a transgender person may find themselves facing discrimination based on a perceived sexual minority status they had never previously had to deal with.

The cisgender individual may also find themselves in a new transgender social environment and may feel like an outsider in that community. After transition, an LGB couple that was previously out of the closet may now find themselves back in a closet, among people unaware of the transgender status of one couple member. This can be isolating. When available, a couples' group for transgender couples may be an immensely valuable referral.

Sometimes, the cisgender member of a couple is not willing to stay in the relationship or is unwilling to participate sexually. Helping them figure out how to end or change the relationship as amicably as possible is the therapeutic challenge, and this will involve much understanding, creativity, open emotional communication, negotiation, and compromise.

LGBTQ COUPLES AND PARENTING

There are many challenges unique to LGBTQ couples who are considering having children. These may include discordance in the wish to have children, how or when to have children, how the partners will contribute genetically (or not, via adoption options), and how to raise them. Further, many LGBTQ couples have to go to great lengths, including expense, to have biological children (21).

The challenges of childbearing differ between gay male and lesbian couples, as well as couples with a transgender member. Gay male couples may have one or both partners contribute sperm to a fertility specialist who assists in parenting through surrogacy. Lesbian couples typically have one or both members carry a child with sperm from a sperm donor.

These scenarios, as well as possible scenarios with transgender couples, pose unique emotional challenges. For example, a cisgender man now married to a transgender man, whom he married when they were a woman, wishes to have children. He has to ask his husband to delay gender transition to first carry a child. How might the transgender man feel being asked to carry a child? For some, this may be a unique opportunity; for others, a horrific proposition.

In other scenarios, a lesbian couple may compete for the attention and affection of the child carried by one partner. When the other partner tried to become pregnant, they learned she was infertile. A gay male relationship may be challenged when one partner is disinterested in having children, given the considerable expense and emotional investment involved in having a child. The issues stirred up around propriety, jealousy, power, negotiation, empathy, and compromise can be intense and challenging for such couples.

CONCLUSIONS

Working with LGBTQ couples requires sensitivity to the unique emotional challenges they face as members of oppressed minorities. It is helpful to understand how oppressive experiences shape an individual's strengths and weaknesses in forming and maintaining satisfying relationships. It is important for therapists to help couples overcome challenges to their self-esteem, capacity for empathy and compassion, ability to compromise, willingness and capacity to communicate, and ability to forgive one's partner's missteps and failures. Understanding and acceptance are good guiding principles for such work.

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