SEX AND THE OLD LESBIAN

Sarah F. Pearlman

"…but my once tender body old age now has seized, my hair's turned white instead of dark, …my knees will not support me that once on a time were fleet for the dance as fawn …but what's to do?"

Sappho, 6th century BCE

First, let me begin by saying there's a range of normal variations in sexual desire and behaviors that exists among Old Lesbians. There is no one normal. No rules. Many exceptions.

Second, that I am not the Lesbian Dr. Ruth.

In today's talk, I'll be speaking about many sexual issues and topics relevant to Old Lesbians.

The following is from an interview with an Old Lesbian.

"My partner of twenty years and I rarely have sex. Maybe two or three times a year. It makes me ashamed. Like something's wrong with me, or her. Neither of us understands it. I still find her attractive. We're still kind of sexual. I mean we joke, kid about sex, touch each other sexually, but we don't have sex, serious sex that ends in orgasm. I masturbate and I think she does too, although we don't talk about it. I still feel aroused, but not enough to do anything. There's just not the push or hot desire like when we were young. To tell the truth, I think we'd both rather relax and watch TV."

We are a unique generation. Old Lesbians who have reached the age of sixty and over. For most of us, it was sexual desire that brought us to an early Lesbian identity. Others had been married and initially thought of themselves as heterosexual. Still others became Lesbians as a result of the Women's Liberation Movement and exposure to Lesbians. But all of us emerged out of an era of concealment and persecution to observe firsthand the struggle for women's liberation and gay rights—witnessing transforming social change and surprisingly to live in a time of increased civil rights and acceptance—including the right to marry.

Sex between women—old and young—is a powerful blend of passionate, intimate, and sensual physicality. Playful, affectionate, caring, and nurturing. Although a term referring to physical stimulation preceding heterosexual intercourse, Lesbian sex can be described as primarily a foreplay-oriented sexuality—actually the kind of sex most women enjoy—and many prefer.

Based on studies, but of younger-age gay women, Lesbians spend more time on sex than heterosexuals, incorporate lots of both non-genital and genital touching, and when having sex, are more likely to reach orgasm. Typically, Lesbians and their partners both orgasm, are more responsive and sexually satisfied, more assertive sexually, more likely to masturbate, and to combine masturbation and sex with partners than heterosexual women.

Lesbians talk more easily about sex—communicating what they like and don't like—are more motivated to gratify their partners as compared to heterosexual men, are less likely to engage in non-consensual sex because of a partner's demands, or agree to sex in order to please a partner. Also, getting it over with is not what Lesbian sex is like. And Lesbians are more likely to report that with, or without sex, their relationships tend to be full of affection.

However, in their book on American couples, Phillip Blumstein and Pepper Schwartz compared heterosexual married, heterosexual unmarried, gay male, and Lesbian couples—finding that Lesbians in committed relationships had significantly less sex than all other types of couples. Conclusions that were widely challenged since all long-term couples experience a decline in sexual frequency and Lesbians have no more a decrease than other couples. It was also Blumstein and Schwartz who invented the phrase "bed death," a phrase that became a common topic of conversation and area of concern to many Lesbians—old and young.

To the medical establishment, female sexuality is a medical issue and frequency the all-important measure of sexual relationship quality—comparing the number of times, rather than amount of time spent, or mutuality of experience. Sex between women, most of the time, can last fifty-seven minutes on average—as compared to sex between women and men. Eighty-five percent of long-term, married heterosexual couples that have sex more than once a month takes on average eight minutes.

To physicians, low desire, less intense and infrequent orgasms, and dry vaginas that make sexual intercourse uncomfortable are the primary medical concerns. Consequently, female sexual functioning is defined in relation to male desire. Absent is the valuing of intimate relationships over sexuality by many, if not most, Old Lesbians. As well as the choice by some to be romantically involved and physical, but non sexual.

Another question is, what actually should count as sex? Lesbians of all ages often equate sex with physicality such as kissing, touching, cuddling, and whole body contact—that may decrease the need for orgasm-focused sex. If sex were defined in terms of mutual sensual and affectionate physical intimacy with or without orgasm, or the frequency of orgasm, or how long sex lasts, sexual satisfaction—or sex concluding in more than one orgasm—Lesbians may well have the sexual lead.

But what Old Lesbians share, along with straight women, is a history of growing up in a time of a crippling socialization that guaranteed sexual shame and confusion. Coming of age when there were good girls, bad girls, and fearful mothers over-concerned with reputation, the danger of pregnancy—and a daughter jeopardizing her chance to marry. There was little or no sex education in schools. Birth control was prohibited or restricted in several states. The pill was unavailable until the 1960's, and abortion illegal until the early 1970's.

Many, if not most of us were ignorant of our female bodies, the need for clitoral stimulation (sometimes actually the existence of a clitoris), and our orgasmic potential. The sexual myth or lie that shaped our sexual lives—if we were once heterosexual—was that there was something called the mature orgasm (thank you, Freud) that was supposed to happen solely through vaginal intercourse—preferably at the same time as ejaculation by one's male partner. Again, a sexuality that served the sexual needs of men—ensuring fears that we were frigid, abnormal, and inadequate. If having sex with men, many, if not most of us, pretended sexual excitement and faked orgasm in order to validate a male partner's masculine image and sexual skill. And to make intercourse as quick as possible.

In the words of one well-known psychiatrist, "The female orgasm should take place at the same time as her male partner. If earlier, it will distract him. If afterwards, it will disturb his relaxation."

Sex between the elderly was likely to be viewed with distaste. If older women showed interest in sex, they were often referred to as “dirty old women”—and those who actively pursued potential sexual partners were called cougars.

It wasn’t until the late 1960’s when Masters and Johnson provided the first scientific information on women’s sexuality, demolishing previous misconceptions including the myth of the vaginal orgasm. Based on their research, they found that all orgasms were clitoral in origin, no matter the source of stimulation—vaginal or clitoral—and that it was direct clitoral stimulation by oneself, or a partner, that produced the most powerful climax.

Finally, there was the groundbreaking publication of the first edition of *Our Bodies Ourselves* in 1971 that not only gave accurate information on sex and our women’s bodies, it also inspired a women-centered health system in order to liberate women’s health issues from the medical establishment. It was also among the first published works to portray Lesbianism as a positive and sexual orientation and lifestyle.

It was Margaret Nichols and Joanne Loulan who were among the first to write specifically about Lesbian sexuality. But with little mention of Old Lesbians. Based on a population of Lesbians who had sought therapy, Nichols focused, at first, on inhibited sexual desire, saying that sexual infrequency was the most common clinical problem presented by long-term Lesbian couples in therapy and the major cause of relationship break-up.

Nichols attributed inhibited or repressed sexuality (Lesbian and heterosexual women that was brought into aging) to a crippling sex role socialization—describing Lesbian couples as a pairing of two sexually inhibited women—both hesitant to initiate or request sex—or pressure partners as if any kind of sexual assertiveness constituted abusive male-like behavior. To Nichols, what then evolved were two women—each one dependent upon a partner’s initiation; each one waiting for the other to begin.

Also, profoundly affecting sexual response was the high incidence of traumatizing childhood sexual abuse, incest, and male violence experienced by many, if not most, women—Lesbian and heterosexual. A violation resulting in lack of trust, shame, and body memory of the

abuse affecting both desire and response. Making sex disturbing and complicated; re-evoking memory of the abuse.

Other sources of inhibition were an over-attunement to the needs and wishes of others resulting in the sacrifice of attention to one's own desires and sensations along with an inclination to misperceive at times and think that one's partner may be disinterested in sex.

And internalized homophobia or shame over being a Lesbian—especially in old pre-movement or pre-Stonewall gay women. These are powerful cultural beliefs that Lesbianism is the result of arrested development or mental illness, together with degrading stereotypes conveying that gay women are masculine, unattractive, predatory, man hating, and women who want to be men. And because heterosexual pornography portrays Lesbians as hypersexual, Lesbianism—like male homosexuality—is often viewed as only about sex.

Many of us suffered greatly because of sexual desire and Lesbian identity.

Thus, once past the intensity of sexual passion in beginning relationships, infrequent or no sex can serve to deny Lesbian identity—although perhaps unconsciously. Sexual inhibition can take many forms like passivity and difficulty communicating sexual needs. Other signs are feelings of embarrassment when undressed, discomfort with sweating or lubrication, a preference for sexual routine, and disinterest in masturbation, or sexual experimentation such as trying out different sexual positions or activities. However, these are not fixed conditions. Inhibitions often disappear in the early stages of a new relationships, or when having sex with new partners.

Also, conflicting, but unspoken, individual sexual scripts—defined as expectations or beliefs as to what sex is, or should be—create other sexual difficulties such as that sex means that each partner should always have an orgasm, masturbation or self-stimulation is not sex, and real sex always includes oral sex. Problems only if sexual scripts differ.

An additional issue is called desire discrepancy or sexual interest differences between couples such as one woman desiring more sex than her partner, when one has little or no interest in sex, when one or the other woman is able to reach (and may prefer) orgasm through self-stimulation, but not with her lover, or one desiring oral sex and the other averse to going down

on sexual partners. The challenge here is sexual communication. Talking about the sexual relationship and hopefully compromising or resolving differences.

There is little question that aging impacts sexuality. Nor is the waning of sexual desire a process of steady decline, but rather an uneven course of change with periodic re-emergence of desire as well as return of the intensity of orgasm of past years.

Aging itself presents multiple challenges including invisibility and demeaning ageist stereotypes as well as unwanted physical changes, age-related illnesses, and mobility limitations. Physical changes that typically begin with, or follow menopause, are weight gain and skin wrinkling—and are a natural part of growing old. There is some evidence that Lesbians are less likely than heterosexual women to be overly concerned with body image and have fewer worries about appearance and weight in themselves or their partners. But gay women are not immune to social conditioning—especially when self-worth has been linked to physical appearance. Consequently, no longer looking like one's younger self can be experienced as a severe and painful loss, oftentimes accompanied by efforts to look or "pass" as younger.

This can also have sad implications in terms of the loss of attraction to one's aging partner in an otherwise devoted and loving Old Lesbian couple. Or a single Lesbian who is sexually disinterested in women of her own age.

The challenge then for many Old Lesbians—single or partnered—is how to reconcile the many losses that can accompany aging. Another challenge is relinquishing the sexual self of younger years as age advances and even older years approach. Also, there are desire and arousal differences across the different decades. Sexuality in women who are in their sixties is likely to be very different than those in their eighties.

For most aging women—not all—there is a normal decrease in desire and changes in sexual response that can affect genital engorgement, vaginal lubrication, and orgasm as age progresses. Although there are multiple causes, these changes occur primarily because of menopause and the decrease in estrogen, progesterone, and androgens; hormones that contribute to vaginal thinning and increasing dryness and likely to cause previously enjoyable penetration by fingers or dildos to become uncomfortable or painful. Also accompanying menopause are hot flashes that often last—although not as often—well past the menopausal years. Moreover, among

Old Lesbian couples, hot flashes in one woman can induce hot flashes in her partner, making body contact and sexual play uncomfortable.

Orgasm can be less intense, or quick, or may take longer to reach—or can disappear for a while, then reappear. I would add that, as you probably know, incorporating the use of a vibrator (often one's sexual best friend) during sex can be invaluable in reaching climax with partners or solitary. There are many different kinds, but electric vibrators are the most powerful and effective, except when camping.

Also, diseases such as diabetes, kidney, and heart disease that affect blood flow and nerve function are increasingly common as one ages. These conditions, along with surgeries such as hysterectomies—and cancer treatments (radiation and chemotherapy)—tend to decrease vaginal lubrication and genital sensation and can affect the intensity, ease, and frequency of orgasm. Anti-depressants, statins, and medications for high blood pressure can also diminish both desire and orgasm.

These effects are not psychological, as some doctors would have you believe.

I would add that sexual activity is safe for most people with a pacemaker. Although the natural heart rate increases during sex, it is the same as the heart rate increase that happens when you exercise.

Also, back pain and arthritic conditions such as osteoarthritis cause loss of flexibility and mobility limitations resulting in discomfort or pain upon movement and/or fear of possible injury and tend to discourage sex. And not uncommon among aging women is urinary incontinence resulting in self-consciousness and shame as well as loss of sexual interest. Best to urinate before sex.

Consequently, any health condition that results in fear of exertion or pain, weakness, chronic exhaustion, or embarrassment is likely to take a profound toll on sexuality. The challenge here is sex talk; sexual communication, many times, not easy. And sometimes best to start by talking about how talking about health conditions and sex is hard.

One question sent in had to do with an elderly woman, now treated with both radiation and chemo with a feeding tube and port. What kind of sex can she have, if still

interested? Probably masturbation. Severe illness tends to result in little or no desire—but sometimes occasional sexual activity can remain important for both pleasure and reassurance that one is still a sexual person.

It is not easy to grow old. Still, although poor health can affect the sex lives of old gay women, physical intimacy and devotion often compensates for the loss of sexual activity.

There are now several FDA approved medications and creams that can enhance desire and prevent vaginal dryness. But I would advise "user beware" and recommend "googling" to obtain as much information as possible, including reading reviews about effectiveness, side effects, cancer risks, if for post or pre-menopausal women, and if they contain estrogen, progesterone, or androgens (testosterone). Many, if not most, seem dangerous or useless, unfortunately.

What is important to understand is that Big Pharm downplays negative side effects for profits' sake and drug companies remain fiercely competitive in the development of new medications that could possibly enhance female sexual response (desire, lubrication, and orgasm). A potentially billion dollar market. I would add that drug companies also profit greatly from drug treatments for side-effect complications. I like to call them effects, not side effects.

One product I can recommend is the Estring**,** a vaginally-inserted ring that releases only minimal amounts of estrogen and is especially helpful in preventing vaginal thinness and dryness. Yet, few doctors recommend the Estring and it is expensive, even with insurance. Another is vagifem, a cream to be inserted first daily, then twice a week. And Membrasisn. What's important is that products are natural and contain minimal or no estrogen (this increases the risk of breast cancer), progesterone, or androgens. Also, avoid glycerin products.

Libitrinex is an all natural product (obtained on the Web) that contains many natural ingredients. It seems to increase energy, lessen fatigue, and has good reviews in terms of increasing sexual arousal.

There is a daily vaginal insert, marketed as Intrarosa, now approved by the FDA, and since it is does not increase estrogen blood levels, it appears unlikely to increase the risk of breast cancer. Prescribed for painful intercourse by doctors (no mention of dildos of insertion of

fingers), it has several unpleasant side effects such as vaginal discharge, rash, itching, and severe dizziness.

Vyleeesi is an injection to be used 45 minutes before sex and is intended to increase sexual arousal, but with mixed results and side effects that include nausea, vomiting, and headache. It is intended for pre-menopausal women.

Addyi has received FDA approval, but is minimally effective and has dangerous side effects such as lowering blood pressure, nausea, dizziness, and fainting. Although guidelines have restricted its sale to pre-menopausal women, there is speculation that it is very likely to be prescribed for post-menopausal women as well as marketed internationally. Again profit for drug companies.

Some studies have shown that wearing a testosterone patch may increase libido, but the FDA has yet to approve any form of testosterone for women. Oral testosterone raises the risk of heart and liver diseases, and hair loss**.** And if the choice is between sex and hair, many women choose hair.

There are medications, similar to Viagra**—**approved by the FDA in the late 1990's—that induce genital engorgement. However, increasing genital blood flow in women does not translate into sexual desire.

But more medications are on the horizon. One will increase genital engorgement when there is nerve damage as a result of surgery. Another will counteract the anti-sexual effects of antidepressants. Both contain testosterone and/or brain chemicals or neurotransmitters, such as dopamine and serotonin, that may increase women's sex drive, but are likely to have multiple side-effects, some potentially quite serious.

Overall, the current news on the medication front is not good.

For many aging gay women, sexual activity remains important— although, for some, less so as compared to one's younger years—and many continue to enjoy orgasm-focused partner sex, or masturbation—or both. However, some do describe that, although sexually aroused, they no longer experience the urgency to pursue or engage in sexual activities. Still, many remain

troubled over the waning of desire—and the loss of oneself as a sexually active person. Others find the absence or infrequency of sex an issue only if their partner experiences it as a problem—and that a diminished libido related to normal aging becomes less significant over time.

Typical of aging in coupled Lesbians is sexual playfulness and a sensual physical intimacy that can include kissing, teasing, holding, cuddling, touching, dancing, and sexual joking that may, or may not, lead to sex and orgasm. One new normal— relevant to Old Lesbian couples—is a combination of sensual physicality, individual masturbation—(sometimes the preferred sexual activity)—and partner sex one to four times a year—or no sex at all.

Old Lesbian couples especially tend to be relationship-oriented and may value intimacy, companionship, and sharing a stable domestic life as much as—or more than sex. Lesbian relationships may be the most intimate of all relationships. Partners are often best friends and it is probably the inclination of many Lesbian couples to be inseparable that passion becomes stifled and sex infrequent. One possibility is that sex can induce feelings of profound intimacy that intensify dependency needs resulting in anxiety when apart. Another possibility is that by adding sexual desire to intense closeness and dependency, there becomes more vulnerability than many individuals can tolerate. Yet, it is the depth of the connection between partners that makes optimal sexuality or great sex a possibility.

Susan Kuchinskas, a science journalist, added another explanation to account for sexual infrequency in long-term Lesbian relationships. To Kuchinskas, pheromones and oxytocin play an important part in low sexual desire. Pheromones have a distinct role in erotic attraction through scented, although subliminal or unconscious, airborne body secretions (or excretions). Often referred to as the “bonding” hormone, oxytocin is produced during physical affection such as cuddling as well as sexual activity and after orgasm—creating feelings of closeness and connection that help to bond partners. Also, its effects are enhanced by estrogen—still produced in aging women.

Kuchinskas suggests that intensely-connected Lesbian couples are constantly emitting and breathing in each other’s pheromones resulting in extra doses of estrogen and oxytocin. Although these increase couple contentment, their calming properties diminish sexual arousal—a phenomenon that may affect one or both partners adding to decrease in sexual interest—particularly among Old Lesbian couples.

Noting that sex happens more frequently in couples that live apart, there is little question that sexual arousal is heightened by factors such as novelty, separation, and delay—and that desire is suppressed by familiarity, ongoing access, and repetitive sexual activity.

I would add that differences can be sexually arousing —such as sexually-charged differences as butch-femme identities as well as ethnic, class, and race—differences that can add novelty and mystery, and provoke and enhance sexual excitement.

Sexual disinterest in Old Lesbian women is likely due to absence of novelty. Many gay men, before AIDS, brought novelty into their relationships through multiple sexual partners and sexual/relationship rules that served to protect couple stability. But for most Lesbian couples, additional partners are likely to be detrimental to the relationship—typically resulting in jealousy, fear of loss, loss of trust, and ultimate break-up. For those couples who wish to remain together and continue or jump start sexual activity, the challenge is how to introduce novelty into the relationship in order to heighten excitement and sustain sexual interest.

If Old Lesbian couples are largely absent in the literature on sex and aging, the old single Lesbian is even more excluded. Some previously-coupled old Lesbians become single due to the death of a partner, others because of relationship break-up. There is also the phenomenon of once-married, and/or previously heterosexual women coming out as Lesbians in later years, sometimes during their sixties and seventies.

For most old gay women, sex is dependent upon the availability of a partner. Many single Old Lesbians hope to meet a potential girlfriend, however, finding one can be difficult and dating resources— except for matchmaking sites on the Internet—few. Cities and areas with large Old Lesbian populations do offer possibilities to meet other women through social, educational, and political events and organizations. But, no longer available is the sexually-charged atmosphere of Lesbian bars, now an uncomfortable social space because of age. Nor is there—for most—the sexual urgency of younger years that compelled active pursuit of other women.

While old single Lesbians may engage in non-genital, affectionate physicality with close friends**,** there are no sexual resources similar to what old gay men possess. No counterpart to

casual or anonymous sex—or engaging in sex with prostitutes or rent boys (rent girls?) prevalent in gay male culture—as paying women for sex, especially to Lesbian-feminists, would be viewed as demeaning and exploitive. Nor are there prevalent models of older women/much younger-women relationships in Lesbian communities.

If dating, old gay women often find the expectation of instant sexual attraction unrealistic, that sexual interest and erotic excitement may take longer to develop—and is more likely to emerge as a result of friendship and companionability. For younger Lesbians, a relationship tend to follow sex. For Old Lesbians, sex follows relationship.

Also, for some, engaging in sex unless in a relationship can be troubling; provoking concern that they might be judged as "fast" or as "sluts." Others can be reluctant to date due to conscious dislike of their aging appearance, lack of social confidence and fear of rejection, or health issues, downplaying qualities such as intellect and sense of humor, as well as sexual skill. Some express concern that since sexual interest has diminished, they may have little to offer a new partner.

However, while some do regret the loss of opportunity to have sex, others find that the decrease in sexual interest results in better decision-making and avoiding inappropriate or ultimately unrewarding relationships. Others admit that they are not sexually drawn to women of similar age, testimony to the power of visual conditioning that determines physical attractiveness. Yet, many yearn for companionship and a life partner—and miss sex with women, finding masturbation pleasurable, but not enough. However**,** masturbation, especially creative masturbation (setting the scene with music, candles, incense) may remain their one sexual possibility.

But doctors rarely will (or never) tell you that masturbation keeps vaginas healthy through maintaining the lubrication process, or that frequent orgasms can have multiple health benefits such as longevity, protection against heart attacks, cognitive impairment, relief from migraine headaches, and insomnia.

Lesbian relationships tend to be over-idealized and Old Lesbians who remain unhappy, unless partnered, may prematurely couple, a situation typically followed by early break-up. Others, however, and sometimes unexpectedly, find that they have grown into a rewarding single

life—set in ways and wondering if they can ever again fit a new partner into a full life—or live with another woman and accommodate to the adjustments and compromises necessary in couple relationships. These Old Lesbians provide an invaluable role model for other single Lesbians: that of aging women enjoying solitude, independence, and their own living space—with time to establish new friendships, discover different interests, and participate in community activities—as well as the freedom to do what they like, when they like.

Actually, for many old single Lesbians, the desire is as much for friendship and companionship as sex.

For Old Lesbians, both single and coupled, who wish to remain sexually active, sexual disinterest—unless addressed—tends to persist**.** Psychotherapy is one option, but best conducted by a clinician trained in both female gerontology and Lesbian sexuality. If seeing a therapist, it may be important to talk about issues of sexual socialization, childhood sexual trauma, and internalized homophobia, as well as improving communication skills and the ability to talk more easily about sex. Issues for couples include ongoing relationship conflicts, conflicting sexual scripts, and differences in preferred sexual activities.

Relevant to Old Lesbians, single or coupled, are a variety of sex-enhancing techniques.

First, desire is most likely to happen by engaging in sexual activity. Called “willingness,” Old Lesbians—single or coupled— rather than trusting to spontaneity, should plan and then begin to have sex, but without desire. In other words, beginning sexual activity, including masturbation (partnered or single) is what brings on desire.

Novelty can be introduced through trying out new sexual positions, changing sexual locations, utilizing different scented lotions and creams, a different vibrator, a new fantasy, and—again, if comfortable—dressing in sexually alluring clothes.

Create sexual fantasies and fantasize during sex to help prevent non-erotic distraction and heighten excitement.

Start with slow dancing (one kind of foreplay), then non-genital touching or massage. Then stop and wait a while. Delay, waiting, heighten excitement. Or begin to masturbate, then stop.

"Simmering," that is, deliberately thinking and fantasizing about sex in order to arouse oneself before beginning sexual activity.

Do frequent tightening, then loosening, pelvic area muscles (those that hold back urinating). Called Kegel exercises (nobody will know you're doing this), these will strengthen pelvic muscles and help with orgasm.

Mindfulness exercises and meditation help with focus and being present. Deep belly breathing during sex intensifies sensation.

Engaging in sexual communication or talking about sex.

A glass of wine and also the choice to use marijuana or other recreational drugs to assist with relaxation jump start desire and intensify sensations.

And watching (if comfortable) Lesbian "soft" porn, specifically produced by and for Lesbians.

More advice. Use extra pillows, take hot showers or a bath, and Tylenol before sex if struggling with arthritis or back pain that affects mobility and limits sexual positions.

Finally, sex, when old, can be gentle, playfully aggressive, or pleasurably forceful, i.e., engaging in bondage and/or other sado-masochistic sexual activities—although perhaps more carefully because of aging bodies.

It doesn't have to end.

Following is a 20-Step Old Lesbian Sex Program.

A 20-STEP OLD LESBIAN SEX PROGRAM

1. Be willing. Sex doesn't happen because of desire. Desire emerges as a result of beginning to have sex.

2. Make a sex date with yourself, or with your partner if coupled. Put aside time for the possibility. Write it on the calendar.

3. Start simmering. Simmering is what you did when you were dating and anticipating sex. Excite yourself by thinking sex, fantasizing about sex (thinking up an exciting fantasy helps). Remember fantasizing about other people is not disloyalty. Begin to masturbate, but avoid any joyous conclusion.

4. Create a sexual scene. Put on romantic music, light incense and candles.

5. Plug in your vibrator.

6. Turn off television (a major enemy of sex), computers, iPhones, e-mail, and anything else that connects you to the outside world.

7. For couples, dress romantically, that is, alluring night clothes (butches, iron your pajamas).

8. Have a small dinner prepared (or lunch if it's late morning).

9. Slow dance to romantic music.

10. Caress your own body. If in a couple, caress your body in front of your partner.

11. Stop all, have dinner and make another sex date with yourself or your partner.

12. Repeat steps 1-10.

13. Go into the bedroom, or any other preferred location.

14. Tylenol and extra pillows for propping (optional).

15. For scent and taste novelty, caress different lotions (coconut, mango, tangerine) all over your body and hers (if partnered), including between each other's legs.

Bring the kitchen into the bedroom, i.e., whipped cream, unsweetened organic jam, chocolate syrup (bring towels).

16. Body awareness: concentrate on body sensations/focus on your fantasy.

17. If in a couple and it doesn't work the first time, stop, laugh, and talk about what it was like—and what it could be like the next time.

18. Turn on television and have dinner (or lunch).

19. Make another sex date with yourself or if coupled, your partner.

20. If that one works, write another sex date on the calendar.

WORKS CONSULTED

Blumstein, P., & Schwartz, P. (1983). American couples: Money, work, sex. New York: William Morrow. Boston Women's Health Book Collective. (Eds.). (1971).

Our bodies ourselves. (1971). Boston: New England Free Press.

Kuchinskas, S. (2009). The chemistry of connection: How the oxytocin response can help you find trust, intimacy and love. Oakland: CA: New Harbinger Publications, Inc.

Loulan, J. (1987). Lesbian passion: Loving ourselves and each other. San Francisco: Aunt Lute.

Loulan, J. (1988). Research on the sex practices of 1566 Lesbians and clinical applications. In E. Cole & E. Rothblum, (Eds.), Women and Sex Therapy (pp. 221-234). New York: Haworth Press.

Masters, W. & Johnson, V. (1966). Human sexual response. New York: Bantam Books.

Nichols, M. (1987a). Doing sex therapy with Lesbians: Bending a heterosexual paradigm to fit a gay life-style. In Boston Lesbian Psychologies Collective (Eds.), Lesbian psychologies: Explorations and challenges (pp. 242- 260). Champaign, IL: Univ. of Illinois Press.

Nichols, M. (1987b). Lesbian sexuality: Issues and developing theory. In Boston Lesbian Psychologies Collective (Eds.), Lesbian psychologies: Explorations and challenges (pp. 97- 125). Champaign, IL: Univ. of Illinois Press.

Nichols, M. (2005). Sexual function in women with women. In I. Goldstein, C. M. Meston, S. Davis, & M. Traish (Eds.), Lesbians and Lesbian Relationships (pp. 207-213). New York: Taylor & Francis Group.

Pearlman, S. (2013, November). The question of novelty, or why can't we be more like gay men. Paper presentation, To Bed or Not to Bed: Sex and the Older Lesbian Conference. Boston: Fenway Health.