

# OBJECT RELATIONS COUPLES THERAPY WITH LESBIANS

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## ABSTRACT

*Object relations couples therapy is distinguished by its use of the ideas of British object relations theorists Klein, Fairbairn, Winnicott, Bion and Guntrip. A number of the central concepts are particularly relevant to work with lesbian couples. For example, the emphasis on the provision of a therapeutic holding environment is helpful for all couples, no matter what the sexual orientation. However, in the case of the lesbian couple whose relationship must be carried on in the context of a hostile society, the provision of a safe holding environment is crucial. Understanding the dynamics of repressed ego systems illuminates how the individual psychology of each member of the couple can be affected by societal pressures which can result in internalized homophobia. The notion of projective identifications provides clarity in reconnecting with lost parts of the self. Finally, knowledge of lesbian sexual practices should be integrated into the therapy. Clinical case illustrations are provided.*

Object relations couples therapy is a relatively new psychoanalytically-oriented treatment (Scharff & Scharff, 1991; Siegel, 1991, 1992; Slipp, 1988) which has received an enthusiastic response. It is an approach which explores the complex infantile roots of irrational adult conflict, within a context that is sensitive and caring. The work of Scharff and Scharff (1991) is of particular interest (Sussal, 1990) as it draws upon the British object relations theory of Klein, Fairbairn, Guntrip, Winnicott and Bion. Existing intrapsychically-oriented approaches to work with lesbian couples (e.g., Falco, 1991) have not applied this frame of reference to psychodynamic understanding and technique. Mitchell's (1989) approach to work with lesbian couples, for instance, is underpinned by Kohut's self psychology.

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A psychoanalytic approach to work with lesbian couples which is based on research and not on prejudice can be an exemplar of the nonjudgemental, nonaversive model Schafer (1983) pleads for as the truly analytic attitude. It should not be assumed, as some do, that a psychoanalytically-oriented approach to work with lesbian couples automatically means that an illness model will be used (Carl, 1990; Coleman, 1986) to relate to homosexuality. While psychoanalysis has a long history of approaching gay men and lesbians from a homophobic frame of reference which has assumed developmental arrest and narcissistic fixation (Lewes, 1989), extensive research has debunked the presumptive myth of illness (Bell & Weinberg, 1978; Gonsiorek, 1982; Hooker, 1967; McWhirter & Mattison, 1984; Saghir & Robbins, 1973) due to sexual orientation.

An object relations couples approach can add to the growing need for more readily available family and couples models for work with lesbians (Usher, 1991), who increasingly present themselves for treatment. It is an appropriate approach for the lesbian couple interested in understanding the intrapsychic, interpersonal, and environmental forces which are responsible for their difficulties.

In this paper I explore some of the central concepts in object relations theory and demonstrate how they can be applied to work with lesbian couples.

### THE SOCIAL CONTEXT

All psychoanalytically-oriented approaches to couples therapy stress the intertwining of the past and the present. However, in work with lesbian couples, it is essential that the social context not be neglected (Usher, 1991). A major focus needs to be placed on the couple-in-situation.

Herdt (1992) argues for the existence of a specifically "gay" cultural system, which he believes has a definite identity, social supports, and institutions. Clear signs exist of such a culture, particularly in urban areas, as manifested, for example, in the existence of gay and lesbian centers, gay pride marches, and gay literature. All of these give purpose and meaning to life, validating same-sex desire, "life-style" goals, and social networks.

Unlike most heterosexual couples, the lesbian couple may be subjected to many kinds of social discrimination as they go about their daily lives, resulting in particular kinds of stresses on the individual, on the couple, and on family relationships. In working with lesbian couples, a careful assessment must include an evaluation of each partner as a

separate individual, an assessment of the unconscious forces flowing between the partners in terms of the balance of love and hate (Dicks, 1967), and special attention to the powerful social and cultural forces that provide context for their relationship. "Connections and position in their society and its subgroups, . . . (and) demands of economic and societal adaptation and role performance" (Dicks, 1967, p.8) are of particular importance to the lesbian couple.

An understanding of how homophobia affects the lesbian couple is central to effective work, since homophobia has the potential to permeate all facets of the couple's life, manifesting itself in their personal, interpersonal, institutional, and cultural relationships (Blumenfeld, 1992). Homophobic beliefs, in which lesbians are viewed as sick, immoral, powerless over their desires, or genetically deficient, can be acted upon in oppressive and destructive ways. For example discrimination is evident in institutions when codes, laws, and policies exclude lesbians from domestic partnership benefits and inheritance. Homophobia displays itself culturally when oppression is legitimized.

Usher (1991) discusses the impact on the lesbian of being "out" in a homophobic society; lesbians, for example, may be subject to and fearful of loss of employment, housing, and even of their own children, for no other reason than their sexual orientation. Some have even been subjected to violent attack (Pharr, 1988). Taking into account the impact of homophobia on the level of fear is important in the beginning stages of engagement with lesbian couples, as the couple may understandably be unusually alert to the levels of acceptance and affirmation they can expect from the therapist.

For example, Sandy and Joan, a couple discussed in more detail below, had to move from their first home after being severely harassed by their neighbors. Eggs were thrown on their house, their car windows were smashed and the tires cut, and threatening notes were left on their doorstep. Life on the block became so intolerable that they had to sell their beloved house. Reconstruction of that period in their lives led to an understanding of prior and present anxieties related to dealing with their sexual orientation.

Lesbian couples tend to value co-equal partnerships which are free of the power politics that often characterize heterosexual couple relationships (Blumstein & Schwartz, 1983; Roth, 1985). Thus, they may be vulnerable to additional stress when they have widely discrepant statuses, roles, or resources. Such may be the case, for example, where one partner has far more income or wealth. While an object relations approach stresses the symbolic meaning of such factors, it is critically important

that the reality generating the dynamics also be addressed.

### CREATING A HOLDING ENVIRONMENT

The major vehicle through which healing takes place in an object relations approach is in the creation of a therapeutic holding environment (Winnicott, 1961). Lesbian couples must be provided with a safe psychological space for therapy. Transference analysis can then be derived from an active form of empathic listening, while the countertransference becomes a diagnostic tool.

The therapist should be alert to particular countertransference components that may occur when working with lesbian couples. Sexist assumptions about women must be examined (Goodrich, Rampage, Ellman, & Halstead, 1988), since such assumptions are built into the male-oriented, ethnocentric models of theory and practice that dominate psychological thought (Green, 1990). Heterosexual therapists who have not examined their own attitudes toward homosexuality may lack sufficient self scrutiny and sensitivity in their work with lesbian couples (Kwawer, 1980). Gay and lesbian therapists, on the other hand, in attempts to create a lesbian affirmative climate, may neglect attention to the pathological components of individual personalities and relationships (Falco, 1991).

If the above issues are dealt with appropriately, the therapist is then in a position to demonstrate openness to personal experience, modelling self examination for the couple. The therapist must show the ability to be controlled yet empathic. This is achieved in part through awareness of one's own feelings through tuning into personal fantasies, a snatch of song, periods of discomfort and uneasiness, or particular relaxation. The therapist can then make contact with the deepest levels of internal distress in a psychosomatic partnership that is similar to the mother's maternal preoccupation with the infant in its earliest days (Scharff & Scharff, 1991). A connection into the couple's deepest level of unconscious communication can occur. Such a depth of contact creates an environment which makes it possible for couples to feel secure enough to do the hard and painful work required to reconstruct the trauma of the past as it repeats itself in the present.

The therapist then models the kind of holding that the couple needs to provide for one another, through centered relating and contextual holding. Centered relating is "... the kind that exists when people who are each other's primary objects reach deeply into each other over time and hold each other at the center" (Scharff & Scharff, 1991, pp. 68-69). Contextual holding refers to the conditions the therapist establishes for

the therapeutic environment, including such contingencies as consistent policies about time of appointment, payment and cancellation arrangements, and attention to the setting in which the therapy occurs (Scharff & Scharff, 1991).

The therapist holds within the undigested elements of painful experience which are then remetabolized in comprehensible language and fed back to the couple to be used by them productively, similar to the way a mother acts as container for the baby as the contained (Bion, 1962). The therapist, in the state of "reverie" Bion (1962) described as existing when the mother takes in the baby's projective identifications through introjective identifications, does the same for the couple in a benign and safe milieu. A transitional space is then created in which a couple can learn new ways to interact with a therapist who is tuned in to the realities of everyday life.

#### CASE EXAMPLE # 1

Sandy and Joan, a lesbian couple in their 50s, had been together for over 17 years. Joan was an administrative nurse with a highly responsible position in a major hospital, while Sandy had risen through the ranks to become a computer systems analyst. Both came from lower socio-economic backgrounds, but through hard work over the years had created a comfortable lifestyle centered around their primary residence and a vacation home upstate.

Joan originally called me to ask for therapy for herself, fearing Sandy would not attend couple sessions; Sandy, however, was open to the idea. The first session revealed that the couple had suffered a series of intolerable losses; their inability to provide mutual holding had not allowed them to mourn sufficiently. Joan, the oldest of six children in an alcoholic Irish family, had lost her favorite brother to AIDS two months earlier. His lover had died of AIDS a few months before. Sandy and Joan had both been deeply involved in caring for the two men, who had even relocated to build a home near them in the country.

During this crisis, Sandy developed a particularly close relationship with another lesbian couple she had connected to through work. Joan complained that Sandy wanted to spend all their spare time with this other couple. Joan felt as if she had not only lost a brother and a friend, but was also in the process of losing Sandy. She needed to tell her story in excruciating detail, slowly and laboriously, since she and Sandy had never really sat down and talked about their feelings before. It felt crucial to me that I listen deeply and provide centered arms around holding, in

other words, demonstrate a warm feeling of acceptance and caring. I realized that the less I spoke the better, and that what was most important was that I be there to provide a space in which this story could emerge and be understood in its full impact.

Joan frequently became tearful, as did Sandy, as did I. The work in the months to come revealed that Sandy was suffering from unresolved issues of loss. Both feared that opening up would result in loss of control and that they would both be totally overwhelmed by feelings of despair, hurt, and anger. Sandy had lost her only brother, whom she had adored, when she was 18. After a turbulent, short-lived marriage she had a "nervous breakdown" and after hospitalization lost custody of her only son.

The couple was quickly able to take advantage of the therapeutic holding environment and worked very hard to make contact with each other on a feeling level, despite their fears. Interestingly, during all of their 17 years together, Joan had never approached Sandy sexually. When Joan began to take some responsibility for moving toward Sandy sexually, Sandy was both thrilled and responsive.

While some patterns are similar for homosexual and heterosexual couples throughout the life cycle (Carter & McGoldrick, 1988), lesbians, who may lack networks of social support or social validation of the relationship, may need to rely more heavily on one another due to the lack of social supports. Krestan and Bepko (1980) suggest that, to compensate for these factors and protect themselves from unwelcome intrusions across the couple boundaries, the couple may overly "fuse" or "merge." Furthermore, internalized homophobia can become exacerbated in such a situation as a result of social isolation (Kirkpatrick, 1991), which in turn can increase feelings of self-hatred.

The inability to openly "tell" one's life, to be forced to remain silent about parts of life experience that are taken for granted in the heterosexual world, can negatively impact both self-concept and self-esteem. The result can be a level of shame and suspiciousness which may be viewed as an adaptive response to censure, but which can also promote schizoid splitting.

Additionally, the lack of socially-sanctioned ritual to celebrate their joining and significant events throughout the life cycle, which heterosexuals take for granted, deprives lesbian couples of opportunities for validation of their relationships. One way lesbians and lesbian couples counter family and social rejection and gain relationship validation is by

creating new "families of choice" (Weston, 1991), that is, families constructed from friends, affirming relatives, and so on. Many lesbians even stay connected to former lovers, who may then play the role of "in-laws". It is crucial that the therapist not make prior assumptions about the couple's lifestyle and that he or she explore the social and cultural dimensions of the couple's life,

The lack of family and social supports may overburden an otherwise highly functioning couple in such a way as to create symptomatic behavior at normal points of developmental crisis. All couples, in the early stages of couple formation, must deal with issues related to fusion versus intimacy, with the relationships they will have with their respective families of origin, and with the initial difficulties in living together and preserving the romance, all the while respecting differentness in the other. The research on the stages of development for lesbian couples (Clunis & Green, 1988) corroborates the centrality of these tasks. However, dealing with societal pressures can create a repressed ego system overladen with internalized homophobia which can make the "internal saboteur" (Fairbairn, 1954) particularly vengeful.

### REPRESSED EGO SYSTEMS

The "internal saboteur" which Fairbairn (1954) later renamed the "anti-libidinal ego," is that part of ourselves which fears intimacy due to prior early experiences of rejection and frustration. An irrational expression of the need to maintain control at any cost sabotages positive possibility. All children, whether they will move toward homosexual or heterosexual orientation, experience either perceived or actual rejection during early childhood and are therefore vulnerable to developing self-protective defenses.

However, in the lesbian couple, internalized homophobia can become layered into the dynamics of each partner's anti-libidinal ego, in recursive fashion creating and recreating an even greater experience of danger in the world.

Fairbairn, differing from Freud, believed that people need object relatedness rather than instinctual gratification. In his view, schizoid splits in the pristine unitary ego of birth occur because of frustration and feelings of rejection. Split off parts of the ego reside in the unconscious and relate to the outside world and to each other internally.

The libidinal ego yearns for love from the exciting object, which is always out of reach. The anti-libidinal ego expresses anger and frustration, all aimed at the rejecting object. These internal repressed ego systems become the vehicles through which members of a couple relate

to each other as either exciting objects for which they yearn, or rejecting objects to which they direct rageful and vengeful feelings.

The workings of the anti-libidinal ego are observable when overwhelming fear of further hurt leads the person to undermine or destroy the relationship progress before being disappointed or betrayed. Creating a storm prevents making contact with the inner emptiness which has come about as a result of infantile trauma, a process that in lesbian couples can be exacerbated by the stress of having to deal with a stigmatized identity.

The libidinal ego itself can also split (Guntrip, 1969). It can hide its heart in "cold storage" out of the fear of further rejection through vulnerability, resulting in profound schizoid personality disorders. Lesbians who are aware of their homosexuality early in life may be particularly vulnerable in this regard. As small children they are exposed to name calling, to hearing others use pejorative terms about them. They develop self-protective defenses which can intensify the need for hiding, resulting in even deeper loneliness.

Balint (1968) realized that this sense of inner emptiness can lead to the fear that if one looks deep enough inside nothing will be found, which he called a "basic fault." There were a number of times when both of the couples mentioned in the case examples herein attempted to sabotage their progress, perhaps fearful of further vulnerability and emptiness. At the celebration of Sandy's birthday Joan ordered a Chinese food banquet with all of the dishes that, at least on some level, she knew Sandy hated. The morning after a particularly loving and close Christmas Eve celebration Joan became withdrawn and rejecting. In both instances the rejecting object in one member of the couple attacked the exciting object in the other in a move designed to create safety. When I was able to point out the true yearning for one another that was covered over by fear converted into hostility, both couples were brought closer.

When these unconscious split-off parts of the self are made conscious in the context of a safe holding environment, great strides can occur in treatment and in life. The couple can then become free to more openly express their needs, longings, love and hate, without having to resort to guerrilla warfare. The roots of these dynamics can then be seen in earliest mother-infant interactions, and reality testing between past and present can occur. If the impact of fears related to societal censure of their love of another woman can also be understood as part of this dynamic, the lesbian couple will then take advantage of the opportunity to love in the moment, with full appreciation for one another. It is then that the deep yearning for love which has been covered over for many years can be expressed and celebrated.



## PROJECTIVE IDENTIFICATION

In object relations couples work with lesbians, the analysis of projective identifications becomes an essential tool for understanding relational dynamics. All individuals experience projective identifications based on archaic remnants of early experience. However, in dysfunctional couples understanding the interweaving of projective identifications can become a powerful assessment and interventive tool (Siegel, 1991). The concept, since Melanie Klein (1946) first conceptualized it, has been widely discussed in the literature (Ogden, 1982; Sandler, 1987; Scharff, 1992). Hinshelwood (1989) defines projective identification as:

the prototype of the aggressive object-relationship, representing an anal attack on an object by means of forcing *parts of the ego* into it in order to take over its contents and to control it and occurring in the paranoid-schizoid position from birth. It is a 'phantasy remote from consciousness' that entails a belief in certain aspects of the self being located elsewhere, with a consequent depletion and weakened sense of self and identity, to the extent of depersonalization; profound feelings of being lost or a sense of imprisonment may result. (p.177)

Thus when projective identification occurs the person projects out negative *or* positive aspects of themselves which are intolerable. The recipient of the projection then introjects the projected part, which the projector then identifies with. This becomes the basis for conflictual interacting as well as empathy, and results in loss of parts of the personality. This is accomplished by the use of defensive delineations, in which realistic appraisals of the other are overlooked in favor of the use of distorted images which emerge out of stimulated anxiety (Shapiro, 1989).

Projective identification must be understood as emanating from the earliest era of life, the paranoid-schizoid position. According to Klein (1946) psychological maturation occurs as a result of going from the paranoid-schizoid to the depressive position. However, it is now thought that throughout the life cycle we oscillate between the two positions (Steiner, 1992). The paranoid-schizoid position is characterized by splitting, in which the mother of the good breast is seen as separate from the mother of the bad breast. In the depressive position the baby must integrate feelings of love and hate, deal with the consequent guilt at the realization of murderous feelings of rage toward the mother who is now understood to be one person, and go on to make reparation through sublimation into various forms of good works. The danger of not being able to contain the guilt ensuing from such realization is either a manic

defense or pathological envy, resulting in further fragmentation of the self.

Projective identification can also be most helpful in understanding the countertransference, as the therapist takes in the projective identifications through introjective identification (Scharff, 1992). This can result in a countertransference which is either concordant, in which the therapist identifies with a projected part of the patient's self, or complementary, in which the therapist identifies with a projected part of the patient's object (Racker, 1968). Feeding back such understanding to the couple enriches and opens up the therapy. Such a powerful explanation of relational dynamics illuminates fixed modes of negative interactions in couples. Etiological roots can then be understood through reconstruction, using clarification and interpretation as the tools to promote insight, enabling the individuals to draw back the projections and create more spontaneous and fulfilling ways of interacting.

#### CASE EXAMPLE # 2

Lorice and Alice were 47 and 41 when they were referred for help with their communication difficulties by Lorice's individual therapist. Both were petite and attractive women who clearly adored one another, and who enjoyed an active sex life. They were distantly-related cousins whose families belonged to an orthodox religious sect. They had become lovers as a result of working together in a family business ten years earlier. Lorice was divorced and had two children ages 24 and 20 still living at home.

The couple, who lived in a suburban town, led an extremely closeted life, and had no gay friends. They were not even out to cousins from an aunt's family who were also gay. The relationship seemed almost a textbook illustration of Krestan and Bepko's (1980) theory that fusion in the lesbian relationship comes about as a result of being cut off from social supports and relying overly heavily on each other to meet all needs.

In the first session Lorice complained that Alice barely talked and that she, Lorice, was finding it increasingly intolerable. Alice, though quite bright and sensitive, seemed extremely constricted and had severe difficulty in expressing herself verbally. My hypothesis was that she was suffering from a schizoid condition whose roots were grounded in her early life. In these beginning sessions Lorice, who was vivacious and energetic, would talk for Alice, interrupt Alice when she attempted to talk, and at the same time would bitterly complain about Alice's

silence. Alice would sit in pained silence, often answering "I don't know" in response to direct questions.

With time, analysis of their early backgrounds revealed that Alice, the oldest of five siblings, came from a household where her mother had been quite silent and her father a "chatterbox." Her job was to provide mothering for her four siblings, to be "good," and never to express angry feelings. This inability to express anger was compounded by her socialization as a woman who was not encouraged to be assertive. The expectation for all women in her family was that negative emotions should be disavowed, adding to the constriction. The middle child and only daughter in a family of three children, it was also Lorice's role to take care of her mother. She, too, had been similarly socialized to hide anger.

A vivid early memory of Alice's was of being left home at the age of nine by her mother to watch her brothers and sisters, while her father was out of town. Falling asleep she awakened fairly late. She panicked to find herself still alone, and did not know where to reach her mother. She called around to all of the relatives until she tracked her mother down. However, when her mother came home she told her not to cry, not to be frightened, not to be angry, and most importantly of all not to talk about the incident any more. Her silence now was understood as containing all of her pain, fear, anger, and yearning for the ability to be appropriately dependent and expressive of her needs.

In Lorice's family her mother was also quiet and her father was the chatterbox. Alice rejected the part of her that needed to express itself into Lorice, out of a transference fear that Lorice would act like her mother who had told her to be silent; thus, she encouraged Lorice to do the talking for both. Lorice took this instruction in through introjective identification and became even more of a chatterbox. Lorice, identified with her chatterbox father who was the caretaker in her family, did not feel she was allowed to be silent. She, however, needed to be able to express her mature dependency needs. She projected her silence into Alice, who would become even more withdrawn. Analysis revealed a profound need for intimacy in both that neither had felt capable of achieving.

In the countertransference there were times when I would find myself either uncharacteristically silent or overly chatty. In time I understood this as coming about as an index of particularly conflictual material, still unconscious, which the couple was struggling with. I would ask myself what might be particularly

frustrating, angering, or enraging for the couple which might be resonating with my own issues as a woman in the same arena. I emphasized the particular importance of getting in touch with their angry feelings as essential to move the therapy along.

Ultimately Alice decided to give up her job as a bookkeeper, which kept her isolated and bored. Her period of unemployment lasted longer than both expected. Despite periods of inactivity and depression, she became increasingly verbal. I had made a series of referrals for them to a number of gay and lesbian organizations, ranging from a businessperson's networking group to a new couples' socialization group forming at the lesbian and gay community services center. Alice took responsibility for following up on these referrals and, in addition, promoted their coming out, in a gradual fashion, to a number of family members.

In response to this, Lorice became more and more silent and developed a symptom of a lump in the throat, for which a number of medical consultations revealed no physical cause. The more efforts Alice made to talk, despite struggling with guilt over living on savings and loans, the more silent Lorice would become. The pull to continue to recreate both of their parents' marriages was great, as only one chatterbox was to be permitted. Lorice had a profound fear that she would only be disappointed if she allowed herself to hope too much for a dramatic change in the relationship. The lump in her throat was a metaphor for the death throes of internal object relations which were comfortable but dysfunctional. Alice struggled with the feeling that it was not permissible for her to express her despair and sense of isolation.

Further understanding of my countertransference revealed my wish to be their friend rather than their therapist and rescue them from their solitude. At other times I felt excluded from their intimacy and wished I could become a member of their large and very involved families. In the transference I became a representative of each of their grandmothers, who had been there for them in a way their silent mothers were not.

When Lorice's father died, Alice's mother asked Lorice's mother to move in with her! Lorice's mother declined. She opted instead to move to Florida to be with her youngest son. While Lorice was saddened by the choice, she nevertheless handled it well. Shortly afterward, Lorice's two children moved out. This enabled the couple to have more privacy and more space in which to reconnect.

Ultimately, Lorice helped Alice find a selling job in her field. She worked very hard at giving Alice space in which to talk, and very hard at expressing her true feelings, even though she still found it difficult to acknowledge angry feelings. Alice's new job required constant interaction with people, forcing her to be more outgoing. Even though the effort tired her, she welcomed the opportunity and began to emerge even more fully as a vital presence. At the time of this writing the lump in Lorice's throat has disappeared.

### SEX THERAPY

Like their heterosexual counterparts, lesbian couples may develop sexual problems. The fact that the lesbian couple consists of two women who relate to one another as sexual partners is critical to keep in the forefront of consciousness, however obvious it may appear to be. The literature frequently cites the diminishment of genital contact between lesbian couples over time, at a level more profound than in heterosexual or gay male couples (Blumstein & Schwartz, 1983; Tripp, 1975). This fact is thought to be a result of the differences between male and female sexuality in terms of drive toward genital contact, but might also be viewed as a result of social constraints on and conventional expectations for women's sexuality.

Sex therapy must therefore be an integral part of an object relations couple approach for lesbian couples, *if* the couple expresses unhappiness with their sexual relationship (Falco, 1991). When combined with the use of the transference-countertransference relationship, sex therapy can enhance a form of therapy which is focused on generating ever greater levels of intimacy (Scharff & Scharff, 1991).

There is a literature on sex therapy with lesbians replete with invaluable information with which the practitioner should be familiar (Califia, 1980; Loulan, 1984; Sisley & Harris, 1978). Decisions will have to be made after proper assessment as to whether a couple wishes sex therapy as part of couple's treatment or through referral to a therapist skilled in this area.

Moses and Hawkins (1986) caution that clinicians should be careful about their referrals and be certain that the referred source actually does work with *gay* couples. They warn about the need to get training in sex therapy, indicating that ". . . it is also important to be sure that therapy done is directed toward increasing sexual functioning and satisfaction for the client as a gay person, rather than toward increasing conformity to imposed nongay standards" (pp. 103-104). This is especially important

for lesbians, who may often see foreplay as an end in itself.

In the case of Lorice and Alice a rich sex life was possible as neither partner needed to talk much in bed! Joan and Sandy needed help in dealing with a degree of sexual inhibition and infrequency affected by years of lack of communication on a feeling level. For both couples the ability to engage in sexual relations was affected by the presence or absence of fighting.

Certain universals about the meaning of a sexual relationship, which can be readily applied to the lesbian couple, are important to keep in mind. Sexuality is grounded in the psychosomatic partnership of mother and infant, and is central as an expression of the emotional commitment made by the partners. Nurturing and loving aspects resonate with the internal object worlds of each. Sex can be viewed as increasing

. . . the possibilities for rejection, disappointment, and anger if it fails or is withheld from the relationship . . . . The quality of sexual life is intimately related to the quality of mutual holding within a marriage. While a good sexual relationship rests on a secure mutual holding relationship, it also performs a reciprocal function of supporting the holding between marital partners. Within this secure contextual holding occurs centered holding in which there is a deep unconscious communication of internal object relatedness through the interpenetration of mutual projective identification. (Scharff & Scharff, 1991, pp. 25-26)

## CONCLUSION

Object relations couple therapy for lesbians for the most part is similar to work with heterosexual couples who are desirous of in-depth healing for a troubled relationship. All couples, no matter what their sexual orientation, present with varying degrees of pre-Oedipal issues which benefit from working through. The therapist must understand that all of us are in need of attachment to objects and all of us have fears of rejection by them. Intimacy within the context of a loving sexual relationship, regardless of whether it is homosexual or heterosexual, provides one of the greatest joys in living. However, a heightened degree of awareness is essential for understanding the impact of the social context on the lesbian couple. Couples therapists have the potential to add greatly to the quality of life for lesbians through providing a holding environment that is supportive and understanding. Nondirective listening can open up knowledge of archaic internal constructs and free energy to deal with normative life crises as well as the added burdens of living daily life in a hostile environment.

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