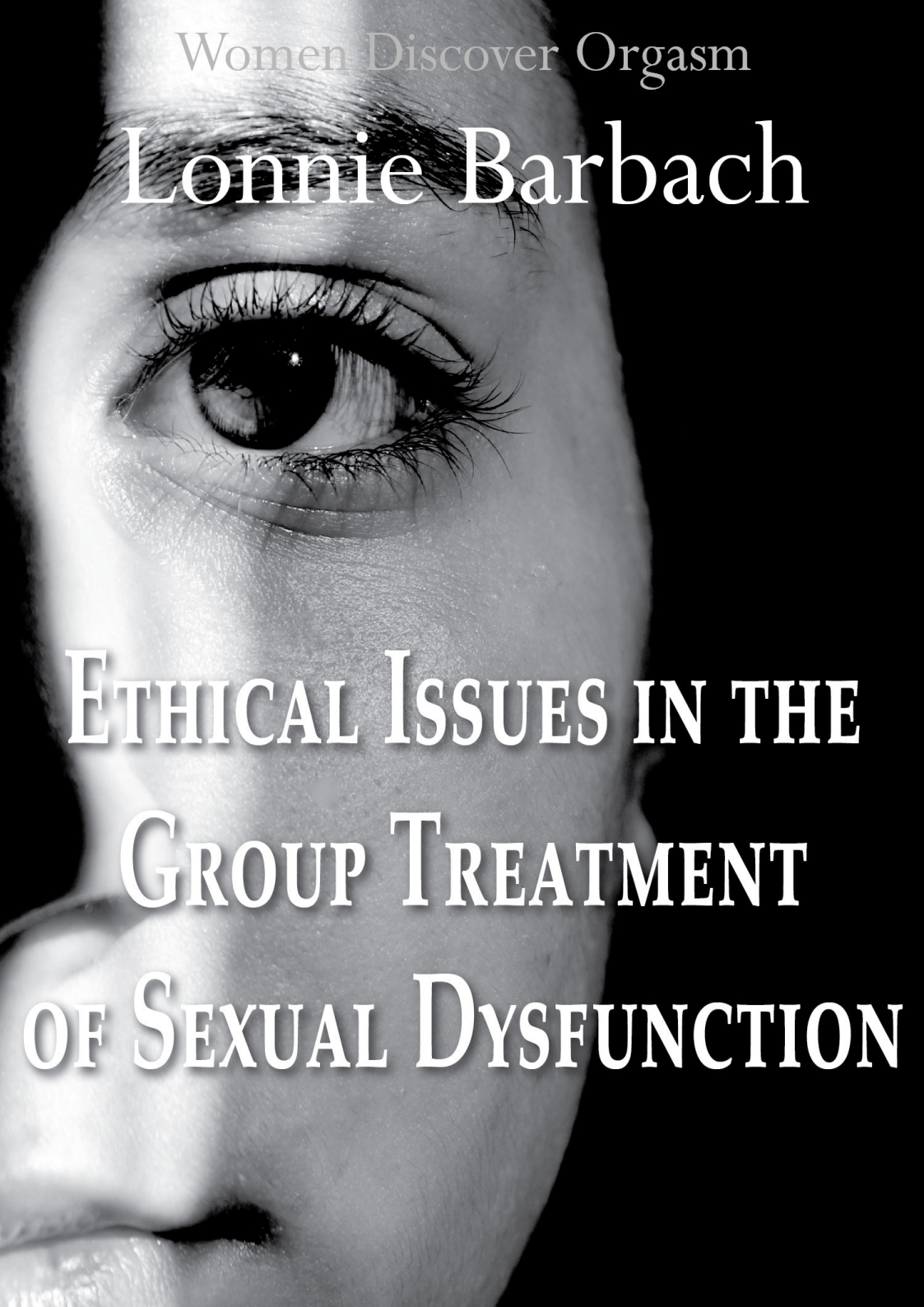
Women Discover Orgasm
Lonnie Barbach
Ethical Issues in the Group Treatment of Sexual Dysfunction

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Confidentiality and Right to Privacy

In any therapeutic relationship, issues of confidentiality and right to privacy arise. In sex therapy these issues are complicated by the highly private nature of sexuality, around which many personal and cultural taboos exist. Sex therapy in a group setting, where participants are required to share highly personal information with other clients, presents unique problems in this area.

In individual or couple sex therapy, the therapist is ethically obliged to guard the clients' confidentiality. Yet in group treatment, the group members are not bound to maintain confidentiality in the same way that therapists are, and although the importance of confidentiality must be stressed, there is no guarantee that one group member will not tell her partner or friends the details of a sexual problem revealed by another group member. To some extent, the women can protect themselves from unwanted exposure by withholding information they do not wish others to have, but withholding can prove detrimental to treatment.

Another serious issue is the right to privacy of partners of participants in group sex therapy programs that do not involve partners directly. A partner in this situation has no control over the information supplied or withheld. This lack of input is of special concern in cases where the partner is not aware of the client's involvement in sex therapy. Frequently, women in preorgasmic groups do not feel comfortable informing a casual partner of their sexual problems, particularly if they have been faking orgasm. Yet relevant details of such relationships must be revealed in the group in order for the women to gain the necessary skills to derive greater satisfaction from sex.

In general, clients and their partners should be forewarned about the problems involved in maintaining total confidentiality in a group treatment program. It is also helpful to disclose only the first names of clients and partners and to instruct group members to disguise the identity of uninformed partners. These precautions can help but they do not totally protect confidentiality and the right to privacy in any group therapy program.

Welfare of the Client

The safeguarding of a client's values is critical in any area of psychotherapy; however, it is a particularly sensitive issue in regard to sexuality. Clients seeking assistance with sexual dysfunctions come from a variety of religious and cultural backgrounds, most of which define acceptable and unacceptable sexual practices. Remember that clients are seeking help for their particular sexual dysfunction as they experience it and not for their sexual lifestyles—although at times there may be a relationship between these areas that must be explored.

Sometimes the sex therapist must expand the client's list of permissible sexual activities in order to relieve a dysfunction. Permission giving is a fundamental therapeutic factor in the treatment of sexual problems. However, permission can easily turn into coercion, especially when backed by peer pressure, and the therapist must carefully guard against this possibility.

Peer support and peer permission make the group treatment approach especially powerful. As I have frequently noted, being in a group with people who have similar problems works quickly to alleviate a sense of alienation and abnormality and to facilitate behavioral change by removing inhibitions. One woman, for example, had had a strict Catholic upbringing, which initially kept her from masturbating. However, when other group members reported success with the masturbation homework, she decided it might be all right for her to do it for "training" purposes. In this sense, the group forms a mini-society to counteract the negative sexual messages of the society at large.

But the same process that enhances change has potential drawbacks. Some members may inadvertently impose their sexual values on other group members, or group support may have a restricting rather than a liberating effect on a given client. For example, if a woman feels morally indignant about the sexual attitudes of other group members she may not express her views for fear of being ridiculed or excluded from the group. In this case, the client may leave the group feeling more sexually inadequate than she did when therapy began.

It is up to the therapist to be aware of differences in values among group members and to acknowledge individual uniqueness so that negative peer pressure is kept to a minimum. (The equally relevant concern of therapist imposed sexual values is discussed in the section on therapist competence.)

All group treatment programs run the risk of not supplying sufficient individual attention, particularly to the more quiet members. In these cases, some individual sessions during the course of the group may be required. In some cases, the group situation may benefit shy members. In one preorgasmic group, a woman was so embarrassed about sex that she talked very little during the meetings. Meanwhile, her attention during the groups was riveted on the other members and she completed all her homework assignments, allowing her to become orgasmic. Possibly, for this client the intensity and personal focus of individual or couple therapy would have been overwhelming.

The goal orientation of any behavior therapy, but particularly sex therapy, can present some drawbacks in a group setting. Since the members' goals are often similar, every member is acutely aware of the progress of the others. Some clients may get discouraged when they compare other group members' successes with their own lack of progress. In these cases, the therapist must maintain the focus on an individualized process, emphasizing that each person's situation is unique and that each will move through the process at her own speed. Ultimate satisfaction rather than speed must be constantly reaffirmed as the objective of the program.

The therapist's decision to terminate treatment when the therapy is not benefiting a client is a difficult one to implement in a group treatment situation. In a group, the therapeutic relationship extends beyond the client and the therapist to the client and the other group members. If, once the group commences, the therapist decides that individual therapy would be more beneficial to one member than group therapy, the issue can become a very complex and uncomfortable one for everyone involved. Asking the woman to leave the group could exacerbate her existing feelings of failure as she compares her progress with that of other group members; in addition, feelings of rejection and exclusion might be engendered.

As previously mentioned, the short-term nature of group sex therapy gives the issues of follow-up and referral greater significance than they have in long-term treatment. A person who successfully completes a sex therapy program frequently finds that a good deal more than her sexual responsiveness has changed as the result of the therapy. Particularly in the preorgasmic women's groups, positive changes in body image, self-esteem, partner communication and interaction, and sense of control over life may not be fully integrated within the brief treatment period. Consequently, the therapist is ethically

bound to insure that adequate follow-up supervision or treatment is available to enable clients to integrate the changes brought about during treatment.

Therapist Competence

The therapist directing group treatment of sexual dysfunctions not only must be competent in general psychotherapy and specifically in the behavioral treatment of sexual dysfunctions but also must understand group process and have adequate group treatment skills. Every group is different and each develops a process or sense of group that is unique. Within this idiosyncratic group sense negative group norms often develop, which can interfere with the treatment of the entire group (see pp. 166-170).

An issue previously discussed concerns the treatment of only one partner in a relationship. A competent therapist must have knowledge of the couple's relationship and interaction in order to understand the absent partner and to aid with interventions that will not worsen the couple's system but work to improve it. Taking a one-sided view may result in the breakup of a relationship, with the excluded partner feeling angry, confused, hurt, and abandoned. I do not suggest that termination of a relationship is necessarily a negative outcome: it may be the most beneficial solution for both parties. However, the therapist should be sensitive to the relationship and cognizant of the therapy's effects on it. Accordingly, some clients should be encouraged to participate in conjoint sex therapy.

A third issue related to therapist competence again, previously mentioned—has to do with personal disclosure on the part of the therapist. In sex therapy, appropriate disclosure can be a highly effective therapeutic technique. Not only does it provide good modeling, but it enables the client to see that it is possible to overcome sexual problems. In a group situation, the therapist's personal disclosure promotes sharing among the members. However, the therapist must appreciate the limits of self-disclosure: she must be careful not to impose her own problems on group members and to avoid offering "liberated" sexual values as the standard for the clients to live up to, thereby replacing one sexual value system with another equally restrictive one. For example, we used to expect people over a certain age to cease being sexual. Now that we know it is possible to remain sexual until an advanced age, we are in danger of giving people the coercive message that they must remain sexually active in their later years. (Some people welcome this time as a respite from sex, which perhaps they never enjoyed or which has

ceased to be enjoyable.)

I hope the reader recognizes that in any treatment of sexual problems it is of the utmost importance to treat each individual's sexual attitudes and values with respect. The more free people are to pick sexual behaviors that coincide with their unique preferences, the more likely they are to experience a satisfying sexual relationship. Treating sexual dysfunctions is often more than merely reversing a symptom. Particularly with women who are not orgasmic, it entails restructuring a sexual encounter to meet each woman's sexual needs. The harder a woman tries to fit into another's framework, the more awkward and strained her sexual encounters are likely to be. Breaking in a partner, like a new pair of shoes, may be uncomfortable in the beginning, but it will create a situation where comfort can exist from that point on.

Dr. Lonnie Barbach is continuing to conduct workshops throughout the country for properly credentialed therapists who desire further training in running women's sex therapy groups. She can be contacted directly at Nexus: 1968 Green Street, San Francisco, California 94123.