Women Discover Orgasm

Major Elements in the Preorgasmic Group Process

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The basic elements accounting for the success of the preorgasmic treatment program are the group process, the behavioral approach, and the role of the leader.

The Group Process

By far the most important aspect of the preorgasmic group process is the format of a small group of women meeting to discuss the intimate details of their sex lives and sexual dissatisfactions and working together to overcome their orgasmic difficulties. Research by Berzon, Pious, and Parson (1963) showed that the main curative mechanism of their short-term therapy was the interaction among group members. They found that the influence of the therapist was less important than the interpersonal feedback, which enabled patients to restructure their self-images in part because they realized that their problems were not unique.

FEELINGS OF ISOLATION AND ABNORMALITY

Entering a group with women like herself who have a similar complaint enables a woman with orgasmic problems to feel less isolated, less like a freak. She no longer needs to consider herself psychologically maladjusted but is now a member of a group joined together against the cultural forces that taught them how not to be sexual. The group members can relate to one another, sympathize, and, most important, accept one another. According to Yalom, "It is not only the discovery of others' problems similar to our own and the ensuing disconfirmation of our wretched uniqueness that is important; it is the effective sharing of one's inner world and *then* the acceptance by others that seems of paramount importance [1970:38]."

Though some people feel more at ease discussing sexual problems privately with a therapist, that same privacy can act to maintain a sense of shame and isolation. Without the physical presence of other women who share her difficulty, the client may believe intellectually that her problem is not unique but deep down continue to feel that it is a mark of horrendous personality and social deficiency. Such a

woman is directly reassured when she sees that at least five other women share her problem—and that they are attractive, intelligent people who seem well adjusted in other respects. These two messages—you are not alone and you are normal—provide enormous relief and are communicated quite easily in the initial sessions just by having the women discuss some of their feelings and experiences with sex, as shown in the following excerpt from the first session of a group.

> Pamela: I feel uncomfortable. Why am I here? Why do I have to be here? I really don't want to talk about it.
>
> Maria: I feel nervous. I am a pretty nervous person anyway.
>
> Jenny: What's funny is that I was feeling all those things you're talking about before I came. When I came in to the waiting room and saw you were all people, I relaxed a little. I am not feeling relaxed to the point where I could strip away everything and get down to the nitty-gritty, but I am much more relaxed now than I was when I was in my car looking at my watch wondering whether I should come or not. I don't know what I expected, but it wasn't real people.

The women confront their sense of shame about sex by revealing their doubts and fears not only to a therapist, who is expected to be understanding and accepting, but also to a group of peers, whose responses are less predictable. The experience of sharing negative feelings and still being accepted by other group members helps free the woman from these feelings.

SUPPORT AND COHESIVENESS

Awareness of having common sexual problems and sexual histories as well as sharing some of their deepest and most shameful feelings of sexual inadequacy, and having these disclosures met by acceptance and understanding by the other group members seems to establish trust and cohesiveness among members almost immediately. According to Yalom, group cohesiveness is a necessary precondition for effective group therapy. "Members of cohesive groups are more accepting of each other, more supportive, more inclined to form meaningful relationships in the group [1970:56]." This support system is essential in order for the women in preorgasmic groups to make changes. Indeed, Dickoff and Lakin (1963) found that patients experienced social support as the chief therapeutic factor. The support in the preorgasmic groups comes from a shared sense of attempting to cope with the same feelings and fears. One woman said to her husband as she was about to do her homework, "At least I know there are five other gals in the Bay Area who are masturbating tonight." Women frequently mention how the other members of the group helped them. For example, one woman claimed that she had her first orgasm

because she imagined the whole group telling her it was all right to do so. Another imagined a group member telling her it would happen if she could just let go.

The support sometimes includes interactions outside the group. Women telephone each other to exchange information or to seek sympathy if one has had a particularly difficult day or problems in her relationship. Members meet for lunch, see another couple for dinner, or meet as a group with their partners for a party. This support system may continue long after the group ends.

When a group is cohesive, peer pressure and group reinforcement make it infinitely easier to cut through individual resistance to doing the masturbation homework and experiencing orgasm than is the case in individual or couple therapy. As an individual develops, she learns to regard and value herself according to how she perceives that others regard and value her—just as a child, in the quest for security, develops those traits and aspects of herself that elicit approval and represses those that meet with disapproval. And experiencing high levels of sexual arousal and orgasm are met by strong approval in the group.

GROUP PRESSURE

In order for the group members to have influence on one another, they must have a sense of solidarity, of we-ness. If a woman feels herself to be an integral member of the group, she is likely to take suggestions seriously and follow directions conscientiously. When she does not, the group tends to put pressure on her. This pressure can be both supportive and coercive.

> Therapist: How are other people feeling listening to Beverly?
>
> Abby: I'm feeling partly strained with you. I feel like you are making a lot of excuses. You don't say the noes that need to be said. A lot of them have been around having people in your house.
>
> Beverly: Houseguests.
>
> Abby: See, it's like I'm trying to say something to you and you interrupt right in the middle with something like an excuse. I would just like you to take time for you. Just stop. Slow down. You're healthy and a lovely person and I'm sure you'll be hanging around on this earth for many more years. You need to take time for yourself.

Beverly would be likely to resist such prodding if it came from a sexually functional therapist who she felt could not possibly understand her feelings, but it is more difficult to resist when it comes from a

woman who is like herself.

Group pressure is probably most important in the early stages of, therapy, when a woman who has never masturbated seeks ways to avoid doing the homework. She may say that she cannot find the time to do it—that her children, friends, husband, or job command all her time and energy. But then one of the group members who has done the homework reports a positive response, and this functions as an incentive to others. Each woman's progress reinforces the idea that the participants will get out of the group only as much as they are willing to put into it and that the women who are doing the homework are enthusiastic and seem to be progressing. In this way, a mini-society with sexually positive messages is created to offset the attitudes held by the larger society that sex is bad, dirty, basically for the man's enjoyment, and so on. The group process also enables the leader to step back from a resistant client who is fighting her authority and let the other group members do the bulk of the therapeutic work, as is illustrated in the following transcript.

> Pamela: I just wish I could have a real physical feeling.
>
> Abby: I want to say to you, maybe because I'm trying to say it to myself, "Do it, do it. Don't put a ceiling on what you can experience." I don't want to feel that you can't have an orgasm. That's a bummer.
>
> Pamela: Well, that's something that may be a reality.
>
> Abby: It doesn't matter how many workshops you go to. There is nothing wrong with your body. It might just be necessary to find the right timing.

Later in the group, the first person to have an orgasm in effect gives permission to all the other women to overcome their fears and experience orgasm also. Each member realizes that if a woman like herself can enjoy orgasm—a woman with whom she can identify, a woman who is in no way more deserving of the experience than she, no better adjusted, no freer of problems than herself—there is every reason *she* can, too. And one by one, each woman has her first orgasm and receives tremendous positive reinforcement from all the other group members and the leader.

RESPONSIBILITY AND EQUALITY

Another advantage of group treatment is that it assists in returning the responsibility for change to its rightful owner—the client. When a woman is treated individually, she often sees the therapist as the

authority and diminishes her own ability and authority. This unfortunate imbalance is exacerbated in couple therapy, for the therapist (or therapists) and the more functional partner are often perceived by the woman as having greater experience and knowledge.

Such a perception can magnify the preorgasmic woman's feeling of inadequacy and her belief that everyone else knows better when it comes to sex.

In the mini-society of the group, the women are equals. Although to some extent the leaders remain authority figures, they teach their clients to assume responsibility for themselves, and this teaching is greatly facilitated by the fact that the group members help one another to solve problems. Women have the opportunity to become authorities, and this experience must not be underestimated: it both reinforces the women in being responsible and enhances their growing sense of self-worth. In the following transcript Maria explains to Jenny how to attract a sexual partner.

> Maria: Just try looking around, making a game out of it to see who's attractive. It's a different kind of looking. Instead of waiting for someone to be obvious.
>
> B.J.: It's not easy.
>
> Jenny: Under certain circumstances, I can make the first move. I can't call up somebody and say, "I met you at a party and I'd like to take you out to dinner," and pay for the check as some of the nice young things that are growing up now can do. No, I can't do that. But I can let somebody know I'm interested.
>
> Maria: Just stare at them. That works. That's how I met Bill. [Laughter]
>
> It was at an audition and I was teaching dance. He came with a friend and it was the third time I saw him. And, I must say, I had a drink or two and I felt very comfortable. And I was dressed nice, and I felt confident and sexy, and I stared at him just like that and he got so nervous and so flustered, he said to me, ''Why are you staring at me?" And I said, ''You know why I'm staring at you." He practically dropped his drink, he was so nervous. And then I whispered in his ear—I wasn't going to let him get away this time—I mean, three times was luck. And I whispered in his ear that I wanted to be with him as soon as possible. I don't know what I said exactly, but something to that effect. He could hardly talk. He was really nervous. The next step was to write my number very sensually, not on paper, but on his hand, and then dramatically disappear and wait for the call. He called me the next night and then he came over. I thought it would be a one-night or two-night thing, but here we are. And that was the first time that I was aggressive, but I cared about him and he didn't even notice me.

In the next transcript, the other group members help in finding a solution to Pamela's problem of lack of arousal.

> Pamela: No, I wasn't feeling turned on at all. It was almost like I should be doing this even though I don't really want to be doing it. There's some feeling. I can touch my hand and it feels okay. And so I was touching my clit and it felt

okay. But it wasn't anything. No feeling of excitement. Nothing built up. I bought the other book, Nancy Friday's other book, brought it home, I read it and it was just like reading the newspaper. It didn't turn me on. And I'm beginning to wonder if I should just get myself in places and in situations that are a little bizarre and it might get me a little bit excited because a physical touch does not do anything. When I use the vibrator I feel nothing, then I feel the pain. And with my finger, I don't feel any pain. I cannot comprehend how someone could have an orgasm masturbating. I don't understand. My body is not allowing it. And so it is just continual frustration.

Therapist: Anybody have any ideas?

Beverly: The other day you brought up slower touching, when you had more sensation.

Pamela: Yeah, I do like a slow movement. I like it. It is a nice feeling. That's all it is. It's no more pleasure than touching myself anywhere else. It's just there. I just happen to be touching it, that's all.

Josephine: When you went to that bookstore and were reading that book, what was different about that?

Pamela: It was an excitement, a tingle. I felt it in my arms.

In ordinary circumstances women rarely talk to other women explicitly about sex. Deliberately sharing in a group situation makes it obvious that although women have some similarities, each is unique. The idea that there are individual differences in sexuality is often greeted with surprise. Listening to others replaces the notion that there is one supposedly normal sexual mold with the understanding that there are numerous normal sexual patterns and that therapy is designed to help each woman discover and be more accepting of her own pattern. For example, some women are turned on by fantasy whereas others do not fantasize. Some women respond dramatically to the use of a vibrator; others find the same sensations irritating. Realizing that there is no one right way to be sexual enables the women to try techniques that others suggest and yet feel free to discard them if they do not prove helpful.

VICARIOUS LEARNING

The group process enables the women to learn from each other's mistakes and successes. As one member discusses her guilty or shameful feelings about sex in depth, the others merely listen or share peripherally; yet each benefits from the reported experiences. The time-consuming process of having each woman deal with the same issues often becomes unnecessary. One woman can provide the therapeutic experience for the rest of the group.

For example, in session five, Pamela had been lying fully clothed in the center of the room on the

floor while all the other group members simultaneously massaged her. Accepting so much caring was painful for Pamela, who has spent most of her energy until this point keeping her emotions inside. She alternately cried and screamed while the others continued to massage her in a caring manner. After a while, I asked them to stop. As Pamela was composing herself, it was obvious that all the other women were moved by her experience and most had been crying.

Therapist: How are you feeling?

Pamela: I feel like I opened up, but I feel like I'm going to block again. It's like all this good feeling I have been receiving is dying right now, just after it is over.

Beverly: I get the feeling that she was really experiencing the caring and warmth that we were all feeling about her, and that feels good, but then she gets that scared feeling when she is not around us and this is making her afraid.

Therapist: How did her experience make you feel, Beverly?

Beverly: I was very moved by it. I realize how much I give to other people and how difficult it is for me to receive from others. I just don't let myself receive. I think maybe others would give, but I don't give them the opportunity.

Therapist: Pamela, would you like to know how the others felt during this experience?

[Pamela nods assent]

Abby: I thought you were incredibly brave and beautiful.

Therapist: What did you feel while it was happening?

Abby: A lot of respect for her. There was so much pain and she was willing to go into it anyway. It made me feel that I could be that brave, too.

Jenny: As I was doing the massage I realized just how much I want from people and how alone I feel sometimes. Maybe I have more friends than you do, but I feel just as alone. I want to be close to someone so badly that it is hard to face it. I'm feeling very sad now, too.

Josephine: [through tears] I can't say what I feel. I feel close to you. Do you known what I mean? I can't express it now.

B.J.: I can't cope either sometimes and it's not so terrible to cry. I wish I could have done what you did.

Pamela: But I didn't want to.

B.J.: I know, but it was beautiful.

The group provides a perfect situation for the women to experiment with and practice taking risks, communicating feelings, and sharing information regarding the specifics of sexual touching.

A fundamental purpose of therapy is to replace self-defeating behavioral patterns with patterns that are more self-serving. In order to make these changes, new and unfamiliar behavioral patterns must be tried out. Although old, self-defeating patterns cause problems, they are at least predictable and familiar. Experimenting with a new behavior initially requires taking risks and consequently produces anxiety. It makes sense, therefore, to begin the process by taking small risks under circumstances that are likely to bring success. Frequently, the safest place to experiment is with the other group members during the sessions. Sometimes I encourage this activity and sometimes the women initiate it themselves. In the following transcript, Josephine experiments with being more assertive and expressive.

Therapist: How shy and unaggressive do you feel in here?

Josephine: The same as always.

Therapist: I would like you to say a sentence describing how you feel about each of us.

Josephine: [Unclear]

Therapist: It's hard, I know. So's having orgasms.

Josephine: I feel something different about everybody.

Therapist: Well, try.

Josephine: I admire you, Beverly, because you are older and you're still so nice. I'm glad you keep on telling me to keep at it. I need that.

Beverly: Thank you.

Josephine: Jenny, I'm glad you're here. I've learned a lot from you about being good to myself.

Jenny: Thank you.

Josephine: I admire you, B.J., because of your ability to keep at it even when you're frustrated.

B.J.: Thank you.

Therapist: How are you feeling now?

Josephine: I feel really, still feel nervous.

Therapist: Because you skipped two people. It's almost like with masturbation. You go almost all the way, then, just before the end, you give up.

Josephine: Do I have to do the rest?

Therapist: It might be nice for you to follow it to the end; give you some practice at it.

[She continues with the last two women.]

In the following homework session Josephine experienced her first orgasm.

One area of risk taking that arises in every group is the willingness to check out assumptions. Most people see implicit messages in the statements or acts of others and then respond as if their assumptions were correct. Martha, for example, on two occasions had asked other women in the group to go out for drinks after the session was over. Both times she was refused. A few sessions later, as she shared some of her hurt feelings, she struggled against concluding that the others were not interested in getting to know her better. She made the assumption explicit by stating that she would ask one more time before giving up. The other women were surprised; their refusals had been based on circumstance and prior commitments. In fact, one woman had intended to ask Martha to go out for a drink after the session that evening and was delighted that Martha was still interested. The incident illustrated to all the women how easily they tended to interpret a refusal as a rejection and showed the value of checking out their assumptions since so often assumptions of this kind are incorrect.

Sometimes it is necessary for the therapist to facilitate the checking out process within the safe context of the group. It had been very difficult for Doris to tell the group that she had female as well as male lovers. Following this disclosure, she became concerned that some of the group members might be upset or might feel differently about her. I urged her to use her concern as an opportunity and suggested that she ask some of the group members directly how they felt about her revelation. She asked three women and discovered to her astonishment that their feelings about her remained unchanged. Feeling secure enough to take risks in nonsexual situations better enables the women to check out their perceptions and assumptions during lovemaking.

GROUP NORMS

Every group takes on a life that is distinctly its own. Part of the uniqueness of each group stems from implicit group norms that evolve out of the interaction among group members. These norms, rarely articulated, can enhance or jeopardize the success of the therapy. If the group develops an esprit de corps in which there is support for success rather than protection from failure the probability is increased that the members will attain their goals. However, some groups develop negative group norms that validate fearfulness and lack of success and interfere with the attainment of individual goals. When all or most of the women in a group seem unable to progress, it is frequently the result of a negative group norm. This can present a serious problem, particularly for leaders lacking experience with groups or understanding of group process. (For a detailed discussion of group norms see Chapter 6).

GOAL ORIENTED, TIME-LIMITED, WOMEN'S GROUPS

Certain characteristics of preorgasmic groups that are less common in general therapy groups may contribute to the effectiveness of this treatment format. For instance, women in preorgasmic groups are seeking a clearly defined goal and can perceive that they are indeed moving closer to that goal. The contract that is established in behavior therapy—one of the key components in the success of this approach—sets a reasonable objective toward which progress can be measured.

The relative brevity of the preorgasmic group, in addition to affording the prospect of more immediate gratification than longer term groups provide, helps keep enthusiasm high and is especially advantageous for women who are resistant. As the end of the group approaches, an eleventh hour effect frequently is seen. These women realize that they must do something to overcome their problem now or never and the imminence of the end of therapy causes them to work harder to realize this goal. Limiting the length of treatment affords other advantages. A certain stability emerges because the group is closed to new members once it begins. And since members rarely drop out, it allows for the creation of a group of optimal size.

That the group is composed exclusively of women is an additional factor promoting cohesiveness and support for changes in addition to the experience of orgasm. In our society women have been conditioned to expect men to wield power and make decisions. Having no males present in the group

requires the women to make their own decisions, to look to other women as authorities, and to respect other women and hence themselves: "In a group without men, women have more freedom to examine themselves in terms of their role expectations and their relationship to other women [Meador et al., 1972:345]." It also frequently enhances the women's ability to relate to other women.

Sharing a symptom, as well as experiences and role expectations, increases the members' ability to understand and support one another as they make changes. It also reinforces each woman's awareness that she is an individual who has rights; that she is deserving of pleasure; and that she can competently govern her life to a degree she never before considered possible.

The Behavioral Approach

The preorgasmic group is a behaviorally oriented psychotherapeutic approach to the treatment of orgasm problems. It structures direct behavioral change which often works more rapidly to eliminate a symptom than does intrapsychic understanding. However, understanding and behavior are intimately connected. Some people require the sense of safety achieved through a deeper understanding of themselves in order to begin the process of change. If a client understands her characteristic way of interacting and can trace it back to its source, if she can see the secondary gains it currently produces or the unreality of some of her fears, that particular behavior begins to lose a certain survival value. Armed with this understanding, such an individual may be better prepared to take carefully calculated risks in order to change her behavior.

Nevertheless, mere understanding with no concomitant change in attitude or behavior is virtually useless, and full understanding is not necessarily required in order for change to take place. Behavioral approaches attempt to institute behavioral change directly. A client tries out the new behavior, with or without insight into the purposes the old behavior served. The new behavior brings positive reactions from the therapist and perhaps from others, which reinforce the new behavior and give the client a new perspective on herself. This simplified framework can produce the same long-lasting behavioral changes as in-depth therapies and in a much shorter period of time.

Preorgasmic women's groups put primary emphasis on specific sexual tasks, or homework

assignments, tailored to the individual's attitudes, interaction patterns, or sense of self, which are integrally related to her sexual functioning. However, even in behavioral approaches, one never really deals with the sexual symptom in isolation. Thus, in preorgasmic groups an understanding of the woman, her background, her relationships, and her sense of ego boundaries determines the pace and the nature of the homework assigned. And without conscientious participation in the homework assignments, the woman cannot expect to make progress in overcoming her sexual problem.

During the first three sessions of the preorgasmic group homework is predetermined and is given to all group members with minimal individual variation. Assignments thereafter are tailored to meet each woman's needs. (The designing of individual homework is described in Chapter 6.) Every new assignment is built upon the outcome of the previous exercise. In most cases this means a progression of assignments leading toward higher levels of arousal until orgasm is attained.

Masturbation is the major sexual learning tool. It allows the woman to maintain complete control over her level of sexual excitation. Should she become uncomfortable with the intensity of her sensations, she can reduce or stop the stimulation. The experience of control is essential. It enables the woman to progress slowly, increasing the intensity of the experience as she feels able to tolerate it. Experiencing control over her sexual response also gives the woman a sense of control over other aspects of her life.

Masturbation is demystified and a great deal of anxiety is alleviated through the step-by-step format of the homework assignments combined with the use of a film showing a woman masturbating. The homework begins with looking before touching and progresses to body touching before genital touching, to orgasm through masturbation while alone before orgasm through masturbation while with a partner, and to orgasm achieved by self-stimulation while with a partner before orgasm achieved by partner stimulation. This procedure allows each woman to approach the goal at her own pace and to experience a number of reinforcing successes along the way until finally she can experience orgasm with a partner. (The orgasm need not occur through stimulation by the penis alone for the therapy to be considered successful.)

The Leader's Role

Preorgasmic women's groups are therapy groups, not educational groups, and require skilled clinical therapists to run them. Although some women will become orgasmic merely by participating in a group, regardless of what the therapist does, the majority will not. Each woman requires specialized interventions that fit her particular personality dynamics, form of resistance, and set of values. Accordingly, the therapist may adopt a different interactional style in relation to each woman. She may be supportive with some and confrontational with others, while maintaining a nonauthoritative and paradoxical relationship with women for whom this style is appropriate. The therapist must also have the requisite training to handle a broad range of psychological problems, particularly when working with very resistant or seriously disturbed women who want to become orgasmic.

As in every therapeutic relationship, the interaction between therapist and client will affect the outcome of the therapy. Each therapist has her own basic approach, but within that approach there is considerable room for variation. Determining exactly which qualities and skills are most helpful, however, is complicated by the dynamics of each group and the fact that other group members and the group as a whole have therapeutic qualities of their own.

What follows, then, is not a prescription but rather a description of the clinical skills, therapeutic techniques, and personality qualities that characterize successful group leaders. Specific interactional styles will not be discussed here, but in Chapter 6 in relation to particular situations occurring in groups. This presentation on general leadership attributes is based on my experience as both a leader, and a trainer, an objective assessment of a series of tapes made by other group leaders, feedback from group members, and an analysis of successful groups as well as those in which members dropped out and in which few if any members achieved orgasm during the treatment program.

TECHNICAL EXPERTISE

The leader's ability to convey her expertise at the beginning, to impart information, and to instill hope is very important in the establishment of group cohesiveness. The group leader is responsible for giving out information on sexuality and correcting misinformation and myths. Therefore, every leader should master the literature on the anatomy and physiology of male and female sexuality. The New Sex

Therapy by Kaplan (1974), Human Sexual Response by Masters and Johnson (1966), For Yourself by Barbach (1975), and a basic human sexuality text such as Understanding Sexual Interaction by DeLora and Warren (1976) will provide most of the relevant information. However, this is a new field and there are both conflicting theories and gaps in our knowledge.

MODELING AND PERSONAL DISCLOSURE

A group leader in any type of therapy is a role model whether she intends to be or not. Her status as leader makes modeling implicit. Therefore, the more "real" the therapist is, the more easily the group members can identify with her.

Self-disclosure by the leader is a disputed subject. Psychoanalytic therapy is based on the assumption that resolution of the patient- therapist transference is the primary curative factor. However, group therapy is significantly different from individual therapy. According to Yalom (1970), the therapist who is self-disclosing increases the therapeutic power of the group because of her ability to determine group norms. She becomes a model for open, honest, direct, and uninhibited communication. By being honest and direct in her attitude and in her approach to the discussion, she promotes honesty in group members. By sharing information about herself and her sexual history she encourages similar sharing among the participants. By demonstrating that she is comfortable with her sexuality, she serves as a model for group members to look to as a possibility for themselves.

If the therapist appears to have no current or past sexual difficulties, the group members may have difficulty identifying with her and may feel that they can never reach her level of sexual competence. I frequently relate traumatic experiences or situations I bungled to illustrate that I, too, have had sexual problems to overcome.

> Pamela: What if you have a person who says everything feels good? I find it's just nicer to have feedback.
>
> Maria: Yeah.
>
> Therapist: I used to kiss my boyfriend's ears a lot. The more I kissed his ears, the less he'd kiss my ears, so I kissed his ears more. Then one day we talked about it and I said, "I really like it when you kiss my ears." And he said, "I hate it."
>
> [Laughter]

> So we were both doing to the other what neither wanted and until we sat and talked about it, we didn't know. Because you do to the other person what feels good to you. But the other person may not like it.

A therapist with no negative sexual experiences may reinforce the members' expectation that sexual responsiveness either comes easily or is hopeless; the women may think that if only they were as "together" as the leader their problems would be over. Obviously, I do not fabricate incidents, but I capitalize on any unfortunate sexual experiences I have had. When a group member is encountering a problem that reminds me of an episode in my own life, I share it. The message I thereby convey is that one can have negative sexual experiences and overcome them, that I can understand members' difficulties, and that their situation is not hopeless. The therapist's ability to disclose can promote group norms of sharing and nonjudgmental disclosure. It demonstrates that the group is not divided into those who are "sick" (members) and those who are "well" (leaders). Berger advocated this type of disclosure: "It is at times very helpful for the therapist to share some past or current real-life problem and to afford a model for identification through his capacity to come through such a problem period constructively [1967; quoted in Yalom, 1970: 103]." (Of course, the leader should not use the group as a place to deal with her own current problems.)

A leader who has the self-confidence to admit her own mistakes gives the women the powerful message that one does not have to be perfect to be a competent person. Nor does one have to be free of all problems in order to enjoy sex and have orgasms.

I easily share my worst experiences in bed and my past difficulties in not saying no to someone for fear of hurting his or her feelings. I received virtually no information about sex while growing up and can always find an occasion to share this fact along with the many misconceptions I developed as a result. Women in my groups frequently mention that they would like to have me recount even more stories about myself. They feel they gain a lot from hearing about how I got myself into and out of some very uncomfortable situations. This degree of sharing puts us on an equal plane. Seeing parts of themselves in someone for whom they have a great deal of respect enables group members to have greater respect for themselves.

I try to do this sharing with humor. When things are not so deadly serious, it becomes easier to take risks, to make errors in judgment, and even to "blow it" completely sometimes. One's experiences may be

painful, but being able to look back and laugh helps keep them in perspective.

It is particularly important to use humor when working in the area of sexuality. When sex becomes too serious it ceases to be fun. And if it is not fun and pleasurable, there seems little reason to participate. Being able to laugh at our awkwardness or at our resistance can relieve anxiety and tension. Being able to do so in the group is the first step in this direction. The following exchange occurred in the second session of a group after the body looking and body touching homework assignments had been completed.

> Beverly: I found my back appears very stocky and there are a lot of fatty deposits all over and it doesn't look pretty at all. It's like a blob of fat and I just wasn't happy with it. So, I don't know if it's exercise that would do it or rolfing or whatever to get rid of the fatty deposits.
>
> Therapist: I wonder what it would be like if you just started thinking about that part of your body and noticing it?
>
> Beverly: Well, my immediate reaction was, I'm finished with it."
>
> [Laughter]
>
> Therapist: Out of sight, out of mind.
>
> Beverly: I don't want anything to do with it.
>
> Therapist: Well, the nice thing about it is that it's behind you.
>
> [Laughter]

The therapist is in a position to set standards that are different from the "sex is dirty—don't talk about sex even if you're doing it—good girls don't like sex" model the women's mothers are likely to have provided. A therapist who is sexual and yet respectable can be a healthy identification figure. However, it is important not to go overboard. The leader who proselytizes her individual values, particularly if her experiences depart significantly from the norm, can have a negative effect on the group. For example, the therapist who has maintained a sexually open marriage for years, who easily relates sexually to both men and women, enjoys group sex, and can have orgasms in 60 different ways may unintentionally be transmitting the message that one has to be like her to be sexually satisfied. Furthermore, group members will have difficulty identifying with her.

The group leader should be aware of the danger that the information she discloses about her own sexuality and how she discloses it may make the group members feel inadequate if their sexual value

system differs considerably from hers. Likewise, it is essential that the therapist be accepting and nonjudgmental in regard to the values and sexual activities of her clients. I have found that respecting a client's perception of a situation, as well as her evaluation of the best approach to attaining her goals, before disclosing my own concerns or attitudes enables me to be more effective in helping her design an approach well suited to her individual circumstances.

For example, I used to believe that a woman who had been faking orgasm should reveal that fact to her partner. Otherwise, I felt, she was only encouraging him to continue ineffective methods of stimulation. I believed that open discussion would bring the couple closer together so that they could begin to learn appropriate techniques. A woman in my first group made me reexamine my thinking. She insisted that her partner would be devastated to learn that she had been faking orgasm. I encouraged her to tell him, but she maintained that he would be terribly hurt. I finally concluded that unless this decision proved to be an obstacle in later sessions she should follow her own judgment. The woman became orgasmic on her own by the end of the program and soon thereafter during oral sex with her partner. She must have done a convincing job of faking because he never knew the difference. This situation and others have taught me that a woman's knowledge of her own situation is frequently better than mine and that I need to trust her perceptions.

SUPPORT RATHER THAN HELP

Although modeling and personal disclosure remain somewhat constant throughout the course of the group, other modes of interaction frequently change.

Permission giving and support from the leader are necessary initially, but as the group develops, the role of the leader must change accordingly. In the early sessions, her job is to replace myths and misinformation with accurate information about female sexuality. While fulfilling this function, the leader is supportive, validating, and permission giving.

Truax and Carkhuff (1967), Heine (1953), Fiedler (1951), and Lieberman (1972) have argued that the effective therapist is one who develops a warm, accepting, understanding, and empathetic relationship with patients. Acceptance by a respected person heightens the client's self-esteem. Support

and positive reinforcement are sometimes necessary to help women in preorgasmic groups make the difficult changes necessary to become orgasmic. Consequently, the therapist must attempt to understand and validate each group member's perspective on her past and present sexuality. In some cases she must give women permission to push on and explore further; in others she must give permission not to try so hard but rather to slow down and relax.

The general therapeutic process entails joining in rather than fighting the women's defenses. If a woman feels that something is too difficult for her to attempt at the time, I support her stance and then ask her to help me figure out what she would feel capable of doing. It is important not to confuse being supportive and validating with solving group members' problems or being responsible for their progress. A supportive and validating therapist can aid the women in self-acceptance; "doing for" them frequently engenders resistance.

As I noted earlier, the average woman in our society is trained to be dependent and helpless. She is taught not how to go after and get what she wants but, rather, how to charm and cajole someone else into doing things for her. Lacking a sense of positive power, many women develop negative power—at least no one can make them feel what they do not want to feel.

Lack of a sense of positive power over her life can lead a woman to withhold in many areas in which she feels pressured, especially when she feels pressured sexually. This withholding is not necessarily on a conscious level. It is frequently an automatic response to the sense that the power lies in the hands of another, usually her partner. Sometimes, however, the women regard the therapist as having power over them and resist what they perceive as the therapist's attempts to make them have orgasms. Even though orgasm was their initial goal in the process they may begin to feel that if they succeed and have an orgasm the leader will win; therefore, they withhold. A leader who plays the authority role—who tries to tell group members what to do and how to do it—can foster this tendency and thereby create resistance.

An excellent illustration of the line between supportiveness and helpfulness comes to mind. After I had been running groups for about two years I received a call from some therapists I had trained. They wanted to consult with me because, they said, "preorgasmic women were getting harder to treat." They

felt that the availability of information on sexuality had enabled women who merely needed a little basic information to learn to become orgasmic without therapy. They needed new strategies to deal with the more difficult patients currently seeking treatment. However, the problem became obvious as I later listened to the leaders express their concerns. With running many groups, the leaders had become so proficient and knowledgeable that they had also become overly helpful and were taking responsibility away from group members. When a woman had a problem or felt stuck, the leader had a solution in the form of an already devised homework exercise. The women were left with no way to assert themselves; they could either follow orders or resist. So they resisted solutions made to seem too easy and proved that they as individuals were indeed too complex to be "fixed" so readily.

One way for the leader to remain supportive without being overly helpful is to use group members as authorities. When questions or issues are raised, the group members themselves offer a variety of opinions and experiences from which others in the group can pick and choose, dispelling the notion that there is only one right answer or one authority.

FOCUSING AND FACILITATION

The therapist must be able to keep each woman focused on the details of her homework and to maintain the group's focus on the central dynamics that affect their sexual responsiveness. A group discussion of sexuality usually touches off an exchange of autobiographical information and a discussion of relationship problems, work problems, and numerous other topics that may be peripherally related to sex but may not require further exploration in order to reverse the orgasmic dysfunction. Being able to separate the relevant from the irrelevant issues is one of the most important skills of the leader.

Once the therapist determines that an issue is not relevant, she must be able to refocus the group without making the woman who is speaking feel devalued. Picking out the essential aspect of the discussion and tossing it back to the group members or making a transition by relating an aspect of one woman's account to a more relevant issue raised by another woman are two ways to refocus the group. If the leader concentrates on facilitating positive group interaction, the women learn to take responsibility for their own progress, and fewer serious resistance problems develop.

A major role of the group leader is to obtain a detailed account of the homework from each woman in order to determine the next assignment. The therapist must be able to visualize the sequence of events as clearly as if she were watching a film of the homework session so she can determine exactly where the woman is encountering difficulties. Also, by having to relate the homework experience precisely, the women learn to attend to relevant details. Both physical and emotional details must be elicited.

Abby: I found out that I can get right up to the point of orgasm in minutes, which I was delighted over, but it doesn't matter what I do. I try turning on my stomach, sideways. I tried all these other positions, and they are great. I had gotten locked into thinking I somehow had to be on my back with my legs apart, which is okay, but I like to do other things and so I tried all kinds of other things but I got up to a point and it started hurting. The sensation became unpleasurable and this is what I realized I've experienced over and over. I can masturbate, but I get to this point where it doesn't feel good so I want to stop. And so I stop. I thought, "Okay, I'll just let the tension drop a little bit." So I'd do that and then it would build up and then I'd stop again and it would build up and it wasn't a pleasurable experience doing that. And my clitoris is a little sore. I didn't mutilate it, but it just seems sore.

Therapist: Now, it's pleasurable up to a point, right? And you are enjoying it. What's the difference in quality between when it feels good and when it doesn't? I know that's hard to explain.

Abby: The difference in quality is a physical sensation, of physically not feeling stimulated. It's hard to tell you. Not burning, but something along that line, something like burning.

Therapist: Where? Where is the burning?

Abby: Over my clitoris or inside under there. You know, the sensation sends tingles throughout my body. I feel myself more excited and then it changes.

Therapist: Does it change in a second or does it change gradually?

Abby: That I can't say. It seems like it's a little more gradually. But it's always getting up to that point. I have to back off from it because of that. And I had another kind of odd thing, of getting way up and then suddenly going dead. Or else there was some kind of release that I didn't know about. All of a sudden, all interest for me was gone. But then I started masturbating again about four minutes later. I could feel that rise again, so it felt like I hadn't completed this thing. But, yet, I don't know what that deadness was either. And so I tried to get into that place and feel what that was like and I couldn't get in touch with it. I didn't know if it was a mental turn-off on my part or a plateau that I needed to hang out with and just do something else. But, the thing that I'm complaining about is that I don't like having that rise in pleasure and it turning to pain because it makes me not want to masturbate.

Therapist: It sounds to me like intensity, not pain.

Abby: It's not a burning like a yeast infection. It's an intensity that's unpleasurable. Is it too much direct stimulation?

Therapist: See, it could be any number of things. I'll tell you what's going through my mind. I've heard before, many times from women, that as they get highly aroused, the intensity of that feeling is foreign and uncomfortable and they don't like it. And it takes a while to get used to it. That's possible. The other possibility is that something's

happening when the feelings suddenly go. So, in either case, I want you to really focus on how that change takes place.

Abby: Okay, so is it a split second before it starts feeling bad or is it a gradual process?

Therapist: Right.

Abby: And then, if it's a gradual process, take it easy and if I start feeling that coming, lay off. Is that what you're saying?

Therapist: Yeah, and to move back down to get used to it. Just like you were doing. The other thing is that I'm not exactly sure what the quality of that tenderness is. In other words, if you move your hands, do you still feel it? Or is it only in certain places that you touch that you feel that intensity?

Abby: No. If I take my hands away from there I can still feel it, sort of a buzzing. It's not pleasurable.

Therapist: What happens if you leave your hand resting there?

Abby: That would be okay.

Therapist: Would that feel arousing?

Abby: It would be neutralizing.

Therapist:' Neutralizing?

Abby: Yeah, And probably, if anything, lower the intensity just a little bit.

In the middle sessions, the leader's primary role is to facilitate the group process rather than to answer questions or design homework assignments. At this point, the leader who involves herself in identifying issues rather than devising solutions will teach the women to focus on themselves and to learn the process of moving from point A to point B by the appropriate steps. The leader can describe various issues that seem to be interfering with the attainment of orgasm, but each woman must decide for herself what issues are relevant to her situation. She can then discuss her plans for doing something about them in terms of a homework assignment.

If the leader is too laissez-faire she runs the risk of seriously deemphasizing the importance of the homework. If she assumes too much responsibility for the women's success, they may experience her as taking over their orgasms and will resist. The appropriate therapeutic stance for the leader grows out of the realization that she does not have the power to make anyone have an orgasm; the women themselves control what they will or will not allow their bodies to experience. The most the therapist can do is to

evaluate the homework assignments carefully, anticipate problems that might develop in carrying them out, and lend encouragement and support in the face of inevitable difficulties.

INTERPRETATION

The therapist does not address the symptom in isolation, although the homework desensitization exercises may make it appear that she does. In reality, the deeper issues that frequently accompany orgasmic dysfunction are indirectly being affected by the process.

As in any therapeutic role, the leader must be able to interpret the behavior, fantasies, and conflicts of the clients when appropriate. In general, however, interpreting the blocks to progress is less crucial than directly helping the women to surmount the blocks.

Interpretations, to be useful, must be expressed to the client in language she can understand, that is, in words that use her own concept of reality. Often, important work can be accomplished merely by reframing the facts and circumstances in such a way as to change their meaning and open up options: "To reframe ... means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes the entire meaning [Watzlawick et al., 1974:95]." The following transcript demonstrates the use of reframing.

> Pamela: I watch T.V. That doesn't help.
>
> Therapist: Some things don't help.
>
> Pamela: I think perhaps if they put me under, you know, like when you go for an operation, you get a needle. And then maybe someone could do it to me. I wonder if that would work. I certainly wouldn't have my head to say no.
>
> Therapist: My feeling is that if you have the power to get your head to turn off like that, you've got a lot of strength in your head to do other things with. It's a matter of figuring out how to do that. The beginning is just to figure out how you can turn off. You have a good, strong head and that can be really positive. I wouldn't want you to lose that ability in the process of learning how to do other things with it as well. It's important that you don't lose that ability. Keep your head in control.

GROUP MEMBER CONFLICTS

Negative communication patterns sometimes develop within the group. However, preorgasmic groups are not encounter groups or T-groups, so it is essential to deal effectively with group member conflicts or process problems without devoting substantial time and energy to them. In most situations, I find that focusing on the feelings of the woman who complains about another's behavior is more fruitful than working with the woman who is perceived as offensive. The woman who complains about another's behavior has more at stake in changing things. For example, in one group, Janice, a quiet member, was very annoyed with Alice, who rarely reported any personal information but readily related numerous examples from the histories of her friends and relatives. When Janice confronted Alice with her behavior, I asked why it upset her so. She replied that to talk is to take risks and whereas she was trying to muster up her courage to risk, she felt that Alice was not. I then asked Janice whether her lack of participation in the group was a result of anxiety or disinterest. "Anxiety," she replied. To which Alice said, "I'm anxious, too, and when I'm anxious, I talk a lot." Thus, it became clear that each woman handled anxiety differently. Janice did not like Alice any better after that interaction, but both women learned something from each other, and the group continued with its task without being bogged down in a personality clash.

SUMMARY

In the preceding pages I have described some of the qualities and skills necessary in leading preorgasmic groups effectively: the expertise of the leader; her ability to be a role model and to set positive group norms; her capacity to support group members while allowing them to develop their independence; her awareness of individual, interpersonal, and group processes; her skill in making appropriate interpretations; and her ability to keep group members focused on developing their sexual arousal until the natural outcome of orgasm is reached. The groups are complex and difficult to run because of the intensity and rapid pace of the process. At no time can any woman be taken for granted. Finally, as in all group therapy, outcome depends not only on the leader but also on the attributes of the group members, group cohesiveness, and group norms; accordingly, groups differ in the amount of change they promote.

Preorgasmic groups are generally led by two female co-therapists. Although co-therapy has a number of advantages, it may not be a feasible option for many practioners, and a lot of therapists who run groups successfully prefer working alone. But a team of co-therapists can offer the group members a greater variety of skills and experiences than one therapist alone can provide. With only 10 sessions in which to reverse a lifelong sexual problem, the co-therapy team is often able to focus more quickly and precisely on the dynamics and blocks that prevent orgasmic release for each of the group members.

The presence of two therapists facilitates interaction in the group. With one therapist leading the group, the process is naturally focused on that one person. Dividing the leadership promotes interaction among members and helps reduce the resistance that commonly develops toward the authority figure.

Between sessions the leaders discuss the obstacles to growth of the group members and plan strategies to work with each woman. During the sessions they can discuss aloud, in front of the entire group, their specific concerns about any of the members. Since the woman is not being directly addressed by the therapists this technique relieves her of the need to respond. Consequently, rather than formulating a defense, she can focus all her attention on the dialogue the two therapists are having about her.

Finally, co-therapy allows the leaders to separate or alternate supportive and confrontational roles. It is naturally more difficult for one therapist to wear these two hats. The following case is a good example of a problem whose solution was facilitated by the presence of a second therapist.

Carole came to the group ostensibly to make sex better for her husband. He was very demanding sexually and she felt that accommodating him sexually would make her life easier. We agreed to help her do precisely that although we detected some resentment in her tone. Carole denied any resentment, insisting that whereas she might have been able to make her husband less selfish and more attentive sexually and in other ways when they were married 25 years earlier it was now too late for him to change.

Carole rarely did homework and never volunteered any feedback. Since she was quite unassertive, my co-therapist and I agreed after the third session to respond to her only when she initiated a discussion. After two sessions of nonparticipation Carole began volunteering reports of minor successes

with her homework. I continued to help her do more things to please her husband. Finally, she got mildly angry and said she felt that I was "needling" her. My co-therapist helped her express her annoyance with me. At first, Carole discounted her anger: "I don't like what you're saying, but I'm sure you didn't mean it and you're probably right anyway." However, with support from my co-therapist, Carole was able to say, "I really don't like what you said." I told her I appreciated hearing her feelings and that she had made me realize that I was pushing her because I could never get a feeling response from her. I then wondered aloud whether maybe that was what her husband was doing as well. This session proved to be a turning point for Carole. She began to see sexual participation as being for her own enjoyment rather than just for her husband's benefit. This breakthrough would have been much more difficult without a co-therapist.

CO-THERAPY DIFFICULTIES

Co-therapy has unique complexities, and numerous issues must be resolved before two therapists can work together harmoniously. Conflicts can arise as the result of different therapeutic approaches, different assessments of the group members and their needs, personality clashes, power struggles, or lack of mutual respect. The co-therapists may feel that they are handling their difficulties well by discussing them outside the group; even so, their problems frequently have a negative influence on the group process. However, if properly handled, disagreement between the therapists can provide the group with a model that reinforces the notion that just as there is no one right way to run a group, there is no one right way to have an orgasm. Of course, leaders must be aware of the danger of setting up a competitive situation between themselves, thereby confusing group members.

When there is friction between leaders, I generally try to determine where the conflict is greatest and attempt to change the process in order to sidestep the conflict. For example, in one group, the co-therapists clashed most noticeably over assigning homework. Though they respected each other, they had very different styles and consequently were unable to interact comfortably. Roz preferred to work out the next homework assignment as each woman completed her report of the previous week whereas Betty preferred to make the individual assignments at the end of the group session. To resolve the problem, each therapist took responsibility for the homework on alternate sessions.

In another group, the two therapists differed in approach, style of doing therapy, and conceptualization of individual needs. They sought supervision because there seemed to be no way for them to work constructively together without confusing the group members and complicating the process. A consultation helped them decide to divide the group, with each co-therapist having major responsibility for the three women with whom she worked most comfortably. This solution did not mean that they were to have no interactions with the other women, but they were to do so only after the co-therapist had finished working with them for that session.

MALE CO-THERAPISTS

To date, most preorgasmic groups have been led by female co-therapists although I have successfully run groups of situationally orgasmic women with a male co-therapist. The presence of a man is bound to affect the process of an all-female group. Meador, Solomon and Bowen found that "women together talk differently from the way they do in the presence of men. The cultural conditioning which most women have assimilated rises to the fore if only one man is present [1972:338]."

If men are to run preorgasmic groups, they must be keenly aware of women's tendency to disclaim responsibility and place the man in the position of authority, particularly when he is vested with the authority of the leadership role. The male therapist must be aware also of his own social scripting, which inclines him to accept this authority role and assume the stance of an expert who will solve the women's problems. A combination of these two tendencies contains the seeds of failure, for resistance is frequently engendered in such circumstances.