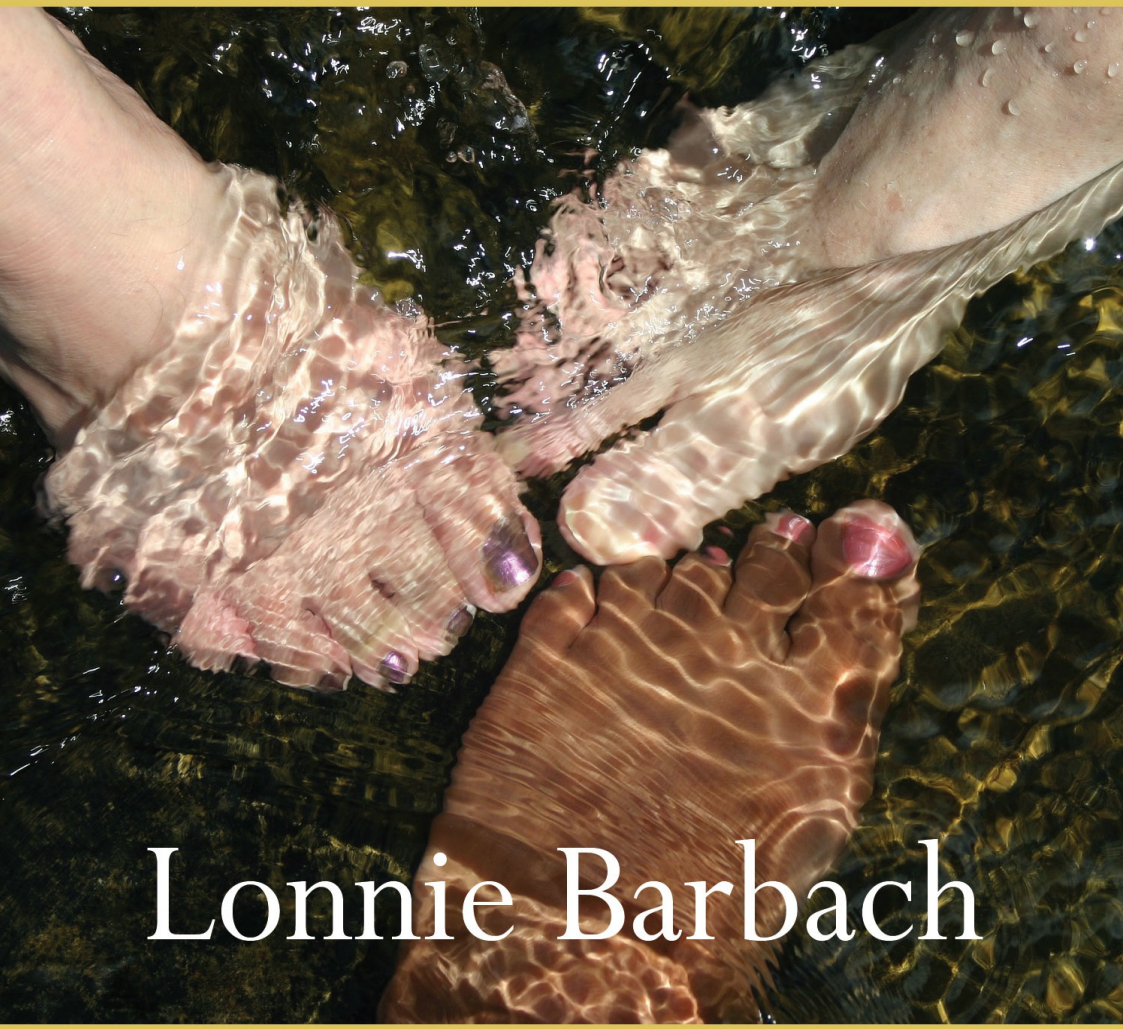
Women Discover Orgasm

Setting up a Group



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The first step in setting up a group is to decide whether to limit it to either preorgasmic women or situationally orgasmic women or to combine these categories in a single treatment unit. Another issue is whether to restrict the group to women only or to include the partners of those women who are involved in relationships.

Types of Orgasmic Dysfunction

Masters and Johnson broke new ground in describing and categorizing orgasmic dysfunction. Before their research, frigidity was defined as any response short of the "mature vaginal orgasm." Masters and Johnson developed two categories of orgasmic dysfunction. They defined a woman with primary orgasmic dysfunction as one who has never attained orgasm by any means: "Every possible physical approach to sexual stimulation initiated by self or received from any partner has been totally unsuccessful in developing an orgasmic experience for the particular woman diagnosed as primary nonorgasmic [1970: 227]." Their second category, "situational orgasmic dysfunction," is composed of three subgroups—masturbatory, coital, and random orgasmic inadequacy. The common denominator is that all women so classified must have experienced at least one orgasm regardless of how it was produced. A woman with masturbatory orgasmic inadequacy can experience orgasm only through coitus and not by self or partner manipulation.[1] Coital orgasmic inadequacy indicates an inability to experience orgasm during coitus, although orgasm can be attained by either manual stimulation or oral-genital contact with a partner. A woman suffering from random orgasmic inadequacy has had at least one orgasm through coitus as well as through manipulative techniques but experiences orgasm rarely and unexpectedly and generally has little desire for sexual expression.

Kaplan, though roughly following the Masters and Johnson scheme, also defines a third category, "general sexual dysfunction," or "frigidity": "The woman suffers from primary orgastic dysfunction if she has never experienced an orgasm; if, on the other hand, the disorder developed after a period of being able to reach orgasm, it is considered a secondary orgastic dysfunction [1974:374]." Women with

general sexual dysfunction derive little or no erotic pleasure from sexual stimulation and may go to great lengths to avoid sex. Frequently, these women are anorgastic as well.

Being primarily a clinician and not a theoretician, I define orgasmic concerns operationally. I consider a woman preorgasmic if she is unable reliably to masturbate to orgasm using her hands. A woman who is irregularly orgasmic with intercourse but cannot masturbate manually to orgasm is considered preorgasmic for treatment purposes since she needs a better understanding of her own arousal process before she can experience orgasm whenever she desires to do so, either alone or with a partner. This would also be true of women who are orgasmic only with vibrator stimulation, since stimulation produced by a machine is substantially different from that provided by a person, and the ability to respond to more subtle stimulation is generally a prerequisite to experiencing orgasm with a partner. I define situationally orgasmic women as those who are currently reliably orgasmic with manual masturbation and possibly in some situations with a partner but who still have concerns about attaining orgasm with a partner. This division is based on the premise that until a preorgasmic woman knows what kind of stimulation is most pleasurable to her and most likely to lead to orgasm, she has very little information to communicate to her partner. A situationally orgasmic woman needs to learn to create in additional situations that which already produced orgasm in some situations.

Objectives

Preorgasmic and situationally orgasmic women differ somewhat in the objectives they hope to achieve through treatment, and this will necessarily affect the focus of the treatment program.

Note that inability to experience orgasm, with or without a partner, is not a sexual dysfunction unless the woman herself defines it as such. I do not consider a woman to have a sexual problem unless she feels she has one, whether or not she has orgasms. Orgasms are nice, and many women prefer their sexual interactions to include them, but enjoyment of sex is not limited to the experience of orgasm. Many women have a satisfying sex life without ever reaching orgasm. Hite's (1976) research, though difficult to interpret because of the open-ended nature of her questions, suggests that 13-33 percent of her respondents felt that orgasm is not always necessary and that sex would be enjoyable if orgasm sometimes did not occur (pp. 434-435).

Masters and Johnson's criterion of success for treatment of female orgasmic dysfunction is achievement of orgasm in 50 percent of one's coital experiences. I do not agree that orgasm 50 percent of the time is a fair measure of success for a woman who desires orgasm 95 percent of the time. (How many men would be satisfied with this criterion of success?) However, many women do not wish to expend the physical and emotional energy necessary to experience orgasm every time they have sex and feel satisfied having orgasms, 70, 50, or 20 percent of the time as long as they are confident that they can have an orgasm when they want one. Orgasms 100 percent of the time would be an inappropriate goal for these women. I believe that women seeking treatment for sexual dysfunctions should help set their own goals; thus, I integrate goal setting into the preorgasmic group process. During the third session, the group members determine their individual goals in behavioral terms (see Chapter 5, for a discussion of goal setting).

The basic goal of the preorgasmic participants is orgasm and the program is designed to teach them to have orgasms through self-stimulation. Once the preorgasmic woman has learned to gain control over and feel good about her own orgasm through masturbation, she learns to ask for or to do what feels best with a partner.

The goals of situationally orgasmic women are far more diverse. The general goal I offer them is to increase their options for having orgasms with a partner by "one new way." This objective is obviously inappropriate for women who are without a partner or who are in an unsatisfactory relationship. However, the goal of orgasm in "one new way" is consistent with the view that there is no one right way to have an orgasm. Once a woman learns the process for experiencing orgasm in one new way, she can apply the process used to learn to have orgasms in other ways. My overall objective is for the woman to leave the program no longer feeling sexually inadequate but knowing that it is within her power to experience orgasm if she is willing to communicate certain information to a partner or to initiate certain behaviors. Learning to be comfortable with these changes may take time and may have to be developed anew with each partner, but there is a considerable difference between feeling that there is something basically wrong with oneself and knowing that the route to attaining one's goals is open if the requisite changes are made. Many situationally orgasmic women in casual or unsatisfying relationships who terminate the group without having had orgasms with a partner consider themselves successful because they no longer feel inadequate and realize that attaining orgasm is not beyond their control. They have a

clear understanding of what they need to do to experience orgasm but choose not to practice the necessary techniques with the current partner or at the current time. At a later date, such women may decide to work on orgasm with different goals in mind.

Issues in Treatment

Preorgasmic and situationally orgasmic women differ in terms of the issues that must be dealt with. Preorgasmic women spend most of the sessions discussing the masturbation homework. A lesser amount of time is devoted to the partner work that is assigned after orgasm is reliably experienced through masturbation. Transfer of the orgasm to the partner relationship is fairly easy for most women who become orgasmic during the sessions. These women initially have little idea of what produces an orgasm. After they learn, they readily accept that what they are doing is normal, and all they have to do is teach a partner what they have learned about themselves sexually.

Most women who are situationally orgasmic can masturbate to orgasm but feel guilty and ashamed about it. As a result, they masturbate very quickly and only to relieve tension. Masturbation is seen as distinct from "real" sex, and most of the women feel uncomfortable about requiring clitoral stimulation to reach orgasm. Hence, they do not expect or ask a partner to engage in the kind of touching that produces orgasm for them when they masturbate. Many of these women even believe that masturbation is responsible for their lack of orgasm during intercourse.

Moreover, situationally orgasmic women often have a fixed manner of masturbating: they use only one position and only one type of stimulation. Generally, their technique was accidentally discovered. Since it worked, they rarely deviated from it. By contrast, a woman who discovers orgasm as the result of her participation in a group is encouraged to try new positions and different types of stroking, which can result in her being less rigid about how she attains orgasm.

With both preorgasmic and situationally orgasmic women, it is necessary first to make masturbation a more sensual and valid experience in order to enhance the women's feelings about themselves as sexual beings. Once a woman feels more accepting of her sexual responses she may be more at ease communicating her needs to a partner. However, the situationally orgasmic woman's negative early

conditioning seems somewhat more difficult to overcome than the preorgasmic woman's lack of initial learning. Furthermore, since general relationship problems which directly affect sexual response are more prevalent with situationally orgasmic than with preorgasmic women, intervention in the relationship system may be required in order to resolve the sexual problem.

Although some of the issues differ, a similar process is used to treat both sexual dysfunctions. Preorgasmic as well as situationally orgasmic women must have the information, support, and permission necessary to enjoy sex. Whether the client is preorgasmic or situationally orgasmic, it is essential to begin with the woman's feelings about herself, her own sexuality, and masturbation. Once we establish a firm foundation in this area, we can proceed to partner exercises or exploring relationship problems. All of these women must develop assertiveness, acquire skills in relating to others and learn to approach their goals through safe, small steps.

Homogeneous versus Mixed Groups

I have run three types of groups: preorgasmic women only, situationally orgasmic women only, and mixed groups with a variety of sexual problems. Within certain limitations, I have found that the mixed group offers the best results. Not only are mixed groups the most practical for the therapist, who may not have a large enough pool of applicants to draw from in order to form a homogeneous group, but since the treatment process for preorgasmic and situationally orgasmic women is virtually identical, group members who are at various levels of sexual self-discovery can assist one another.

Preorgasmic women must begin by taking the time to give themselves sexual pleasure and, in order to learn what an orgasm is, must attend to the minute details of the masturbation process. Consequently, they help the situationally orgasmic women attend to the stimulation techniques they already use during masturbation and thereby prevent them from prematurely moving into partner related activities. Situationally orgasmic women provide preorgasmic members with a variety of self-stimulation techniques and with descriptions of orgasm that are more diverse than those the leader alone could provide. Also, the preorgasmic women have the benefit of observing the situationally orgasmic women's progress with couple assignments. This modeling better enables them to integrate their orgasms into a partner relationship, which is especially significant should attainment of the first orgasm take most of the

group sessions, leaving little time during the course of the treatment to concentrate on couple activities.

The drawbacks of a mixed group are the greater number and diversity of the issues discussed. Since the process is a rapid treatment program, the fewer issues requiring attention, the more time available to delve into the most relevant ones. If none of the women can have orgasms with masturbation, the therapist can focus on the fear of loss of control, disgust about masturbation and women's genitals, and other common concerns, at the beginning, leaving time for relationship issues after a number of the women have learned to experience orgasm on their own. A mixed group requires the therapist to divide her attention between self-sexuality issues and issues involving partners from the start. This two-pronged approach tends to diffuse the focus of the group, particularly when women suffering from vaginismus or lack of interest in sex are included in the mixed group.

In mixed groups that include only one or two preorgasmic women, the identification process and the domino effect of one orgasm leading to another may never have the opportunity to develop. In fact, the preorgasmic women may become discouraged and feel that they are too far behind the situationally orgasmic women ever to catch up. Hence, although these women may benefit in the same nonsexual ways as the situationally orgasmic women, they may receive insufficient support to experience their first orgasm. Including a minimum of three preorgasmic women in a mixed group of six or seven aids in alleviating this drawback.

Including Partners

A number of formats exist for directly including partners in the therapy program. One format consists of inviting partners to attend the second group session, which contains the majority of the educational information, and the seventh or eighth session, which focuses on couple issues raised during the course of therapy. Unfortunately, this approach can have a divisive effect on the group unless all the women have partners who are willing to participate. Therefore, women without partners or those whose partners are unwilling to attend the sessions must be in a separate group so that all group members feel they are receiving comparable treatment.

But homogeneity also has its drawbacks: it gives the women only limited exposure to significantly

different kinds of relationships. Single women do not gain perspective on the range of relationship problems that can develop over time, and married women forget about the anxieties and difficulties being single entails. Such sharing may make it clear that neither acquiring nor discarding a partner in itself holds the solution to their problems.

The advantage of homogeneous groups is that more time can be devoted to relevant issues. Groups with women who have willing partners can spend time extensively exploring the issues involved in changing the ingrained patterns that develop in an old relationship. Groups for women without partners can focus on issues relevant to finding new partners and beginning new sexual relationships that are healthy and rewarding. In general, the prognosis for women whose partners are unwilling to participate in the therapy program is limited at best.

Another way to include partners in the treatment process is to run a men's group concurrently with the women's group. Although this format has not been fully evaluated, it appears to have a major drawback: many men are unwilling to attend such a group because they see the woman as the one with the problem.

The best approach is to mix women with and without partners in the initial ten-session group and then to add another two to four sessions for those women with partners willing to participate. This series may include only three or four couples. I have found that preparing the partner by including him in the initial interview and then following up the women's group with some couple sessions generally provides a framework for handling common sexual and relationship issues adequately. Most partners are receptive to the couples' sessions and participate actively. They seem to benefit from talking with other couples in much the same way that the women benefit from talking with other women. Another alternative is to offer conjoint sessions to couples who want them or to couples with extensive problems. As has been noted previously, a ten-session couples' group for women and their partners is another workable alternative to the women's group program (Ersner-Hershfield, 1978).

Group Size and Scheduling

Groups with fewer than five members cease to operate as a group because each woman has an

insufficient number of other women with whom to identify and interact. In addition, when there are few participants, the group members generally feel pressure to contribute. Consequently, they may look more to the therapist for leadership and direction, which encourages both resistance and a tendency to assign authority to others rather than to assume responsibility themselves. These problems have been reported by most leaders who have started groups with fewer than five women.

Two hours per session is an optimal time for a group of six or seven women. Since each woman is expected to report her homework progress at every session, a larger group would require too much time. And the longer the session, the greater the opportunity to waste time. Keeping the session short enhances the sense that every moment is important.

It is desirable to select the participants so that each shares significant external characteristics with at least one other woman. For example, if there is one woman over 50 years of age, there should be another who is also over 50; likewise, there should be two married women, or two gay women, or two women of an ethnic or racial minority. If a woman sees herself as too different from all the other members she may isolate herself and benefit less from the group. When such balancing is not possible, the therapist should be aware of this problem and promote a sense of shared experience.

Originally, the preorgasmic groups met twice weekly for five weeks. This schedule was established to accommodate students, who were the initial clients. We later discovered that the intensified process that developed by meeting twice weekly added to the therapy's effectiveness. It is natural to avoid doing something that causes discomfort or anxiety, and in therapy groups that meet only once a week, clients tend to put off doing the homework until a day or two before the next session. Holding sessions at four- and three- day intervals (Monday and Thursday, Tuesday and Friday) provides continuous positive reinforcement and increases the likelihood that the women will complete the homework assignments daily. Completing the assignments in turn maximizes the likelihood of orgasmic release.

However, a five-week program did not provide sufficient time for progress with partner homework since it was more difficult for the women to set aside an hour a day with a partner than it was to do so alone. A schedule of twice weekly meetings for three weeks followed by weekly meetings for four weeks for a total of ten sessions seems to combine the positive aspects of both programs. Ersner-Hershfield

(1978) compared twice weekly and once weekly sessions, and found both schedules to be adequate, although she suggested that a mixture of the two is most beneficial.

Selecting Participants

The first therapeutic contact is usually made over the telephone. Most women are shy, embarrassed, and ambivalent about asking for help with a sexual problem. A concerned but straightforward approach on the part of the therapist is desirable. If the therapist is uncomfortable asking explicit questions about sex, the client most certainly will feel ill at ease.

An initial office interview is important for a number of reasons. Given that the woman has probably always had a problem with orgasm, talking with her and setting up an individual session immediately will capitalize on her motivation to seek therapy at this particular time. It will help alleviate her initial anxiety and insure that she will remain interested until a group can be formed. Otherwise the therapist may find that when she thinks she finally has enough women to form a group, her waiting list has dwindled.

The initial interview not only provides the woman with the opportunity to talk with the therapist, see who she is, and evaluate her skills and attitudes, but also enables the therapist to determine whether group treatment is appropriate for this client. If the woman is in a stable relationship, I include the partner, whenever possible, in the second half of the initial interview to help me determine whether couple therapy might not be more appropriate. The initial interview also gives the therapist a chance to formulate a strategy by which to approach a particular woman and her situation and an opportunity to explain the group process in detail and to ascertain whether the woman is willing to make the necessary commitment. This preparation allays the woman's anxiety and increases the probability that she will show up for the first group session.

In the initial interview I try to elicit specific information in a number of areas. How does the woman see her problem? Does she experience it as a problem for her alone, for her partner, or for both of them? Does she now have orgasms? Has she ever had them? If she says she has never had an orgasm, I ask whether she ever has orgasms with masturbation. Many women who are orgasmic with masturbation do

not consider the experience they have alone as having anything to do with sex. If I mention masturbation first and do so directly, without embarrassment, I am likely to get a straightforward answer, as well as a sigh of relief, especially if the woman has never talked about masturbation to anyone before. If the therapist is vague—asking the woman whether she experiences "fulfilling sex," whether she is "satisfied" by her partner, whether she has orgasms in "any other way"—the woman may feel too insecure and anxious to state explicitly what she does sexually for fear that it is outside the realm of the "normal."

If a woman says she has never had an orgasm either with a partner or with masturbation, I may inquire as to her expectations of orgasm. Sometimes women are having orgasms but do not know it because they expect the experience to be different from what it is. In one group, a woman described sensations in the sixth session that clearly sounded like orgasm to me. When I told her so, she was disappointed—she had been having these feelings for years. She was expecting the earth to move and to be at one with the universe when she had an orgasm.

If a woman has had orgasms in the past or currently has them with masturbation, obtaining the specifics of the experience is important in determining the choice of treatment. If she has been orgasmic with masturbation in the past but has not masturbated in years, the interview may provide an opportunity for her to get a head start by masturbating during the interim between the initial interview and the first group meeting. Few women lose their ability to have orgasms with masturbation. If she is orgasmic with masturbation, oral sex, or manual stimulation by a partner but not with intercourse alone, an educational program that stresses the role of direct clitoral stimulation in attaining orgasm might be a more appropriate initial intervention, with group treatment a possibility if education alone proves insufficient.

If a woman is orgasmic with masturbation but has not been orgasmic or only irregularly orgasmic with partners, preorgasmic group treatment may be most appropriate. However, if she is orgasmic with masturbation and once was orgasmic with her current partner but is no longer, I would press for further details about when the orgasms stopped and what important events occurred at that time. Frequently this situation indicates a relationship problem and may be dealt with more appropriately in conjoint therapy. Only the therapist's experience and intuition can help here. If there appear to be serious

relationship problems in addition to the sexual concerns, I may decide that couple therapy should precede or run concomitantly with a preorgasmic group. When the partner also has a sexual problem, conjoint sex therapy alone, simultaneous conjoint sex therapy and preorgasmic women's group therapy, or conjoint sex therapy following completion of the preorgasmic group may be beneficial.

Women who are turned off to sex are frequently the most challenging cases for sex therapists. Power struggles within the relationship are the most common cause of this problem, especially when the woman has been attracted to her current partner in the past and is seeking therapy mainly at his request. In these situations, the initial contract with the woman is crucial. To agree, explicitly or implicitly to help her feel more sexual with her partner—translated into the woman's language as "for" her partner—will almost always produce resistance. However, success usually results from following a basically paradoxical approach; that is, being skeptical about whether any progress can be made and accepting as a goal the woman's being able to experience sexual feelings just for herself regardless of whether or not she chooses to act on these feelings.

Eleanor is an example of such a woman. She had been married twice and in both cases enjoyed sex while dating but gradually lost interest in sex after marriage. Once married, she experienced sex as a duty and either rebelled or submitted resentfully although she continued to experience orgasm during sex.

I refused to help Eleanor to enjoy sex more with her husband since that would have placed me on his side and she would have fought me as well. Instead, I agreed to work on her getting turned on sexually for her own pleasure if and when she wanted to feel aroused again. At some future date she could determine whether she wanted to share those feelings with a partner. She agreed, and having completed certain body looking and touching exercises, some assertiveness training, and several assignments to practice flirting with other men, Eleanor began to have more intense orgasms with her husband and to feel better about herself sexually. Moreover, Eleanor and I made it clear to her husband that he did not have the power to alter her level of sexual interest since it was totally in her head. This interpretation served to reduce the pressure he had been feeling to do something to arouse her. He could then stop pressuring her to enjoy sex, which in turn reduced her need to resist. Eventually Eleanor began to feel more aroused and was enjoying intercourse a few times a week, which made her and her

husband happy.

Regardless of whether the woman is situationally orgasmic or preorgasmic, I like to know how she accounts for not having orgasms. Everyone has reasons to explain the unexplainable. Answers like "My mother never talked to me about sex" or "1 didn't know until recently that women could have orgasms" do not provide much information. But answers that include a history of childhood molestation, an incestuous relationship, or fear of growing up and assuming responsibility can yield very important psychodynamic clues to the absence of orgasm. (These "psychological hooks" are explored in greater depth in Chapter 6.)

Ascertaining whether the woman has any physical or medical problems that might affect her sexual functioning as well as obtaining information about the type of contraception she uses and her comfort with that method can sometimes provide invaluable information. In one case, all the woman required to experience orgasm was a change from a diaphragm alone to a diaphragm plus a condom to enable her to feel safe enough from pregnancy to relax during sex.

Including the partner in the second half of the initial interview has advantages and disadvantages. The chief disadvantage is that it may give the woman the message that her orgasm is her partner's responsibility or that she must have a partner to be sexual. Either of these messages may be corrected once the group begins. On the positive side, meeting with the couple reassures the partner about the process and provides the therapist with a better picture of the relationship.

Leading a group composed of only half a partnership requires skill in understanding relationship dynamics. Both partners will have equally self-serving interpretations of events, and thus the woman's perspective on the relationship and on certain incidents inevitably will be biased. However, there are rarely pure villains and victims in relationships. Both people play a part in maintaining the system in its current state even though neither is satisfied with the way things stand. As the group progresses, I need to know how the woman can best present the couple exercises to her partner. Meeting the partner before the group begins gives me some sense of both his personality and the dynamics of the relationship and a better idea of how to proceed.

No adequate screening procedures have been established for eliminating women who cannot work

constructively in a group situation, whose relationship would not benefit from this form of treatment, or for whom a rapid treatment program would be insufficient to meet current life needs or personality structure. Until further research in this area has clarified the salient issues, I recommend that the therapist not work with a client with whom she is very uncomfortable. For some therapists, this might entail screening out psychotic women. However, if the therapist is comfortable working with seriously disturbed women, it is entirely possible for these women to realize their goal of orgasm within a group setting. Surprisingly, sexual therapy seems to help the reality testing of psychotic women and the exercises seem to enhance their ability to concentrate.

However, possible negative reactions from other group members present a drawback to including these women in a group. If a noticeably disturbed woman is avoided by other members or is treated differently, she may fail to benefit from the group process. This places an added burden on the therapist to make sure that the woman feels a part of the group and is given a chance to join in interchanges. Women who are depressed, however, appear to pose no problem to the group. As a matter of fact, many women commence group treatment in a somewhat depressed state since helplessness and loss of control are characteristic of women who do not have orgasms.

A final consideration in the selection process is whether a woman is currently involved in any other form of psychotherapy. If a woman is currently in therapy, I want to know whether she is in it for her sexual problem and whether her therapist knows of her intention to join a preorgasmic group. If the therapist has referred her, I assume that he or she knows about the process and has confidence in it. Some therapists like to discontinue individual therapy until the group ends; others prefer to continue the individual treatment in order to work on nonsexual issues. My concern here is that the woman not bring up issues in her individual sessions that concern the group because if she works out group related issues elsewhere, she limits her participation in the group and deprives other group members of her insights. Refraining from discussing the group in her individual therapy also minimizes the chances of eliciting contradictory messages from the different therapists involved and thereby minimizes the possibility of her playing one therapist off against the other.

It is not uncommon (especially if the individual therapist is a male) for the woman to be uncomfortable discussing sex with her therapist and hence not to inform her therapist of her wish to be

involved in a preorgasmic group. In this situation I inquire as to how participating in a group might pose problems. If the woman can imagine no potential problems, I suggest some; for example, how she feels about withholding important information from her therapist or how she feels about being caught between two therapeutic modalities. I usually suggest that she discuss the group with her therapist. However, I am less concerned about her talking to her therapist than I am about her own clarity regarding the process. Women who refuse to talk to their therapists about the group but who clearly separate the two therapeutic experiences in fact experience no difficulties. Those who are more confused or for whom seeking additional therapy may represent an important issue in individual therapy generally will be better off if before joining a group they are helped to come to terms with the possible conflicts.

The most complicated situation arises when a woman who is already working on sexual issues with her therapist or whose therapist advises her against a group joins anyway. This decision can easily lead to competition between the two forms of therapy and between the two therapists involved. If the group is successful, does this somehow prove her other therapist inadequate? Will she feel she has to discontinue individual therapy, even though it has been helpful with other problems? If she thinks so, she may find herself thwarting her sexual goals in order to maintain her relationship with her individual therapist. Discovering these issues mid-group can complicate the sex therapy considerably and in some instances markedly interfere with the woman's attaining her goals. Therefore, it is imperative to clarify these issues before the group has started.

Explaining Details

Once I determine that a client is appropriate for women's group sex therapy, I explain the details of the process. The topic of masturbation should be broached gently with women who have never masturbated since many of them have strong inhibitions against it. Most women accept the idea if I tell them, "We have found that women in your particular situation are generally out of touch with their own bodies. Does that fit for you? The easiest way to get back in touch with your body is through self-stimulation. Consequently, each woman in the group first focuses on learning to have orgasms on her own through masturbation and then learns how to communicate what she has discovered about herself to her partner." For situationally orgasmic women this message can be modified: "Now that we know that

you work, that you're not broken, what we have to find out is why what works for you on your own is not happening when you have sex with your partner." In both cases, it is important to stress that since the woman's partner is not in the group, she will have the responsibility to teach him what she learns from the sessions.

It is necessary to explain that agreeing to participate in the program means that the woman is willing and able to attend all the group sessions and to do an hour of homework a day. The group will be a place to discuss the homework and related issues. Pointing out that all the sexual assignments are done at home will relieve many women who are concerned that they might have to disrobe or masturbate in the group.

After I have explained the process, I want to be sure that the program is acceptable to the woman. If I detect even a hint of hesitancy, I encourage her to take time to think it over before she accepts a place in the group. I want her to be certain that she wants to do it for herself and not because I am pressuring her. In this way, I am assured that the woman is highly motivated. If a woman is unsure and I try to convince her that she should join the group for her own sake, I am taking on more responsibility then I should, and once the group begins she may resist me or drop out.

In my experience, any manifestation of ambivalence such as frequent telephone calls before the first group meeting or unusual fee- setting difficulties warrants postponing the decision to include the woman in a group; she can join a group at a later date when she feels less unsure. One woman called me three times prior to the first session to get further details. First she was concerned that her problem might be too different from that of the other group members; then she feared that external pressures might make this an inappropriate time to begin. When she called a third time, I told her that she had so many reasonable concerns that I did not think she should join the group. She then became very quiet and her voice began to quaver. The fear that came up immediately when she realized she might not be included assured her of how important this therapy was to her, and her ambivalence vanished. The tactic proved to be very successful. She was a woman whose power came from withholding and she most likely would have tried to defeat the therapist had she not felt in charge when the group began.

Once it seems clear that a woman does want to join a group and is willing to commit herself to the

group sessions and the requisite hours of homework, I ask her how she thinks she will try to sabotage getting what she now says she wants; for example, by not doing the homework, by procrastinating, or by getting ill. I ask this question because it both gives the client insight into her own resistance and puts her in control. She is telling me how she will sabotage herself; I am not telling her. But more important, having her articulate her resistance in this way often prevents her from manifesting it. For example, one woman's method of sabotage was procrastination. At the second session she admitted that she was not doing her homework but since she had told me that she might procrastinate, she decided to do her homework so that I could not say, "See, you're procrastinating"—this was the beginning of her taking responsibility for herself.

Finally, I assign my book For Yourself (1975) to prepare the woman for the group process and the homework exercises. At first I was afraid that the reading would inhibit the process by prematurely giving the women too much information. However, a few of the therapists I had trained began to assign the book when prospective clients initially telephoned. They found, contrary to my expectations, that reading For Yourself generally had a facilitating effect. Although some women were concerned about the partner exercises, most of them were better prepared and more willing to undertake the homework than women who had not read the book. The group members reported that reading stories of women like themselves was both reassuring and motivating.

Confirmation

As happens in other forms of therapy, some prospective clients experience so much anticipatory anxiety about the process that they either forget about the first session or cancel at the last minute. This can be devastating to a closed group whose success depends on an optimal size and a balanced makeup. Collecting a reasonable deposit is one way to insure attendance. Fee collection depends on the policy of each therapist and on the ability of the client to pay. Some therapists collect half the fee as a deposit and the second half midway through the group. Others collect by the session or by the week, with the deposit used as payment for the last session or two.

I inform all the women that the group starts on time: nothing dampens enthusiasm more than waiting for stragglers, and soon those who normally arrive on time begin arriving late. Therefore, I

always start at the appointed hour. I generally find that after a session or two everyone comes early. Once I arrived five minutes late for a group and found the members already meeting with the door locked. I really felt I was doing my job well when they expressed enough self-confidence to begin the session without me.

Notes

1 That Masters and Johnson considered inability to achieve orgasm through masturbation a problem rather than condemning those who masturbate is in itself an indication of changing cultural attitudes toward sexuality.