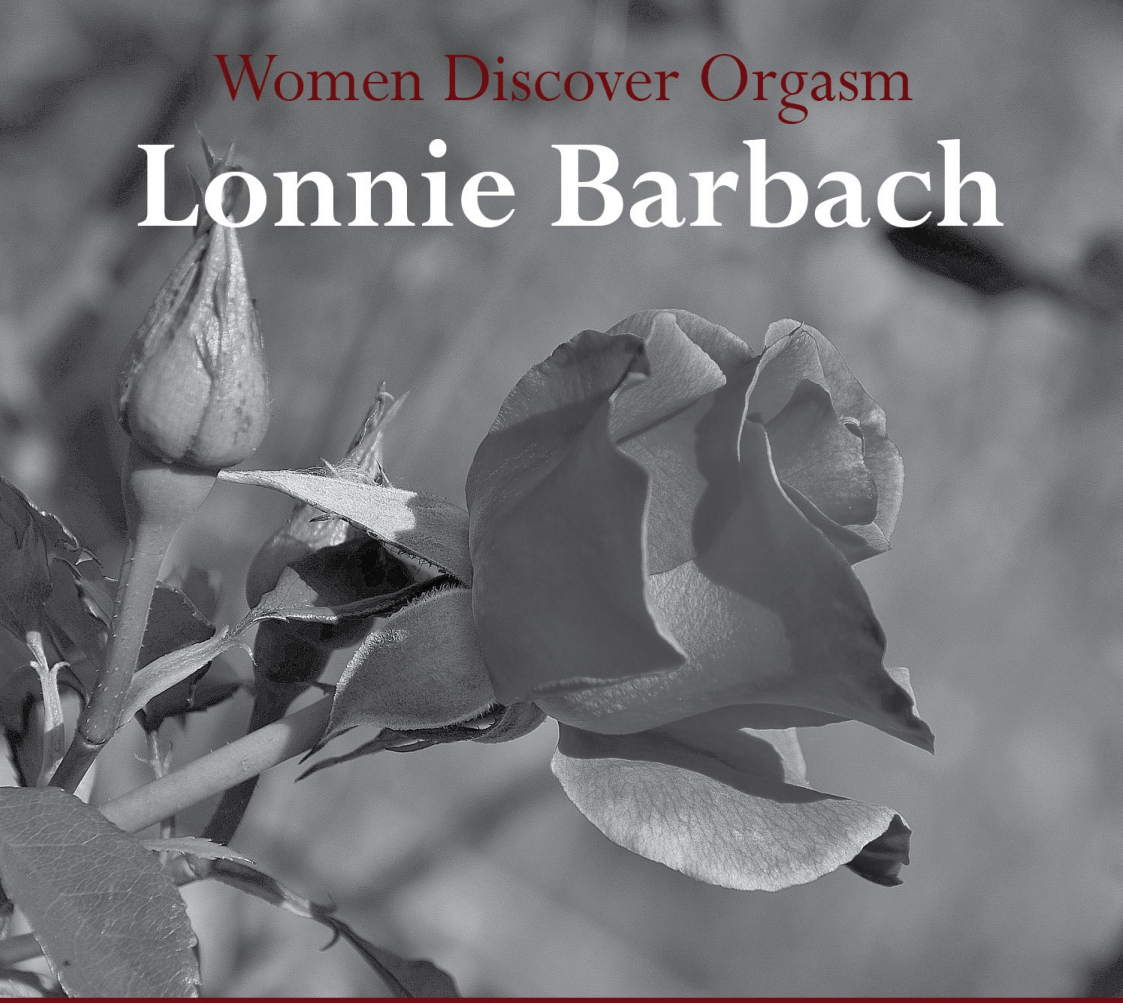
Women Discover Orgasm

Lonnie Barbach



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The Middle Sessions

Sessions five through seven constitute the major working portion of the group. The stage has been carefully set and a sense of group trust and cohesiveness should be well established. The therapists have had the opportunity to learn more about each woman and how she responds to the homework assignments, as well as to various therapeutic approaches and stances. The task now is to individualize the homework assignments and the therapeutic strategy to meet the special needs of each group member.

Individualizing the Therapeutic Approach

Each woman is unique and therefore requires a therapeutic approach that takes account of her particular personality. Of course, some women fulfill their goal regardless of how the therapist interacts with them, but others may fail to respond to treatment if the interactional stance of the therapist is not appropriate. Previous chapters have suggested some of the techniques in the therapist's arsenal.

Support, paradox, abdication, confrontation, and joining the resistance are the principal interactional styles. During the sessions, the therapist spends time with each woman according to her need in terms of dealing with obstacles to becoming orgasmic as well as according to her readiness to work. It has always seemed to me a waste of time to struggle with someone who is not quite ready to change when there are other group members who are ready. Those women who make no progress in the early meetings usually become sufficiently disappointed or angry to take charge of the session in order to obtain the time and information they need later on.

PROVIDING SUPPORT

A supportive, accepting, permission giving approach is generally a useful one for the therapist to follow in the first three sessions. With a woman who is very tentative and frightened, such a stance provides a sense of security and safety and should be maintained beyond the third session as long as the woman seems to be doing her homework and confronting her fears at a reasonable pace, given her personality and history. Cory, for example, entered the group feeling quite depressed about sex, her

marriage, and life in general. After the second session, in which she was very emotional, crying and expressing her feelings of hopelessness, she began to do the homework. By the fifth session, she was feeling better and looking better, even to the extent that her cheeks were pinker and her complexion less sallow. The group she was in appeared to be stuck in the sixth session—no one had had an orgasm—so I gave the women the assignment of imagining how they would feel thirty-five years later still never having had an orgasm. This exercise was an attempt to break the group norm of no one succeeding (see pp. 169-170). At this point, Cory turned sallow again and said how disappointed she was. She felt that earlier I had given her hope and that this had enabled her to make progress. Now that I was pessimistic she felt like giving up. The assignment, while appropriate for the other group members, was clearly inappropriate for Cory. Thereafter, I resumed my supportive stance with Cory and she became orgasmic before the eighth session.[1]

DEALING WITH RESISTANCE

All forms of sex therapy work by attacking the client's defenses directly. This frequently increases his or her anxiety and thereby actually engenders resistance. Some people's ego boundaries are so poorly defined that they need to defend themselves vigorously against being overwhelmed by another person. In sex therapy, which produces a high level of anxiety, they express this need by resisting both the therapy and the therapist.

Women in preorgasmic groups who present difficulties because of their passive resistance can be easily identified in the first or second session. They generally present themselves as being helpless. They may report incidents of reacting to a partner in a passive-aggressive manner. They frequently question the therapist's authority and imply that they do not like to follow orders or have always been "rebellious." Sometimes they indicate that they do not expect the program to work for them though they are willing to go through the motions. It becomes perfectly clear that despite their helpless, inadequate manner, these women are firmly resistant to the help they solicit. The resistance is a response to their feeling a lack of control over their lives. They carefully guard their boundaries for fear of merging or losing themselves, and they prove their strength by showing that others cannot change them. Although this process is self-defeating, it generally represents a lifelong pattern. In therapy, these are the women who win by defeating the therapist. Sometimes, however, they experience orgasm after the group is over,

thereby proving that the leader and treatment program were of no assistance and that they had to do it by themselves. If I perceive that a woman is manifesting this form of resistance, I discontinue the supportive stance and abdicate, join the resistance, or use a paradoxical approach.

Abdication

The resistant woman can "win" by withholding her orgasm, thus proving her autonomy. She is the client most likely to fail in groups led by inexperienced therapists. It is crucial for the therapist to recognize this common resistance, withdraw from the perceived power struggle, and, in doing so, relinquish her investment in the client's achievement of orgasm.

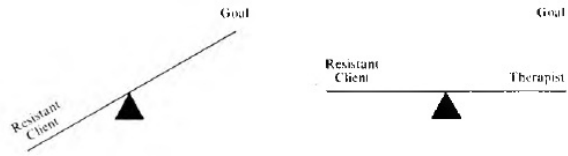
Sometimes the therapist can clarify the power struggle by describing and interpreting it dynamically, but in a brief therapy program such as the preorgasmic group process it is far easier for the woman to achieve orgasm if the group leader takes a helpless rather than an authoritative position. Not surprisingly, when a woman gives herself credit for attaining orgasm despite the therapist, she is beginning to redefine herself as a winner—as someone who has the power to go after and obtain what she wants. This aspect of the leadership role, which enables a woman to break away from the authority figure in a healthy way, may be one of the primary factors in her starting to take control of her life.

The therapist's willingness to be "defeated" early in the group by not having all the answers, by making mistakes, by being ignorant in a way that requires the woman to help her find answers rather than fight her, and by being excessively understanding, exaggerating the difficulty of the woman's situation in such a way that she is required to assume positive control in order to correct the therapist—all help bypass the resistance. The resistant woman still wins by defeating the therapist, but attains her original goal as well. Examples of this will follow.

Joining the Resistance

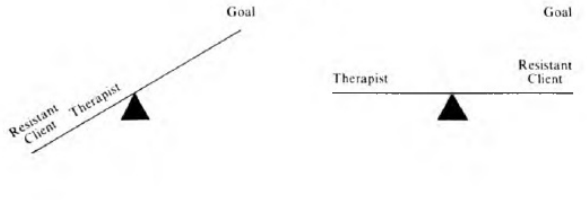
Sometimes I visualize this dynamic as a seesaw. If a woman tells me how terrible her situation is and I counter by saying it really is not so terrible, or if she acts confused and I give her the answer, we remain locked in equilibrium. I provide her with an opponent to prove wrong. We each defend our positions and a stalemate results.

Figure 6-1



However, if I join her, acknowledging that things are terrible— so terrible I am surprised she can attend the group sessions, let alone do the homework—if I suggest that she is trying to move too fast and should slow down (when in fact she has not tried at all), and if I say I have no answers to her problems, I move over to her side of the seesaw. To fight me, she must move to the other side. Hence, by remaining in opposition, she finds herself on the side that is most likely to enable her to achieve her goal.

Figure 6-2



Paradox

The paradoxical approach, as described by Watzlawick and various co-workers (1967, 1974), consists of directing the client in various ways to continue or to exaggerate self-defeating or anxiety-producing behavior.

> If one person wants to influence another person's behavior, there are basically only two ways of doing so. The first consists of trying to make the other behave differently. This approach fails with symptoms because the patient has no deliberate control over this behavior. The other approach . . . consists in making him behave as he is already behaving. ... If a therapist instructs a patient to perform his symptom, he is demanding

> spontaneous behavior and by this paradoxical injunction imposes on his patient a behavioral change. The symptomatic behavior is no longer spontaneous; by subjecting himself to the therapist's injunction the patient has stepped outside the frame of his symptomatic game [Watzlawick, Beavin, and Jackson, 1967:237].

Prescribing the symptom results in giving the woman a new kind of control over her behavior because she can no longer indulge in it unconsciously while claiming to be helpless. What occurs by this intervention is a change in the system: "Symptom prescription—or in the wider, non-clinical sense, second-order change through paradox—is undoubtedly the most powerful and most elegant form of problem resolution known to us [Watzlawick, Weakland, and Fisch, 1974:114]."

The use of paradox is illustrated in the following transcript.

> Pamela: It just happens. I block the feelings.
>
> Maria: Spontaneously?
>
> Pamela: Yeah, I can't plan it.
>
> Therapist: Well, then notice it. Actively block the feelings.
>
> Pamela: I would think that if it happens that I feel turned on I should build up that feeling.
>
> Therapist: That doesn't work for you. Because even if you build up, you'll still block eventually. Seems to me more reasonable at this point to find out how you block, to get that more under your control by blocking actively, noticing that process better.
>
> Pamela: I think it's a very unconscious thing, very subconscious.
>
> Therapist: Maybe as you're doing the blocking, actually cut off the feelings and see if it gives you an idea.

Examples of ways to handle resistance are contained throughout this book, but I shall present a couple of cases here to illustrate the aforementioned approaches.

Dale was never able to complete her homework: friends, family, illness, and other concerns kept interfering. When the group members or therapists tried to help her solve her problems (fighting her resistance), she always had an explanation for why their solutions would not work. Her responses usually took the form of "Yes, but ... I can't afford a baby sitter;" "Yes, but ... he would get angry if he had to take care of the children." The therapists realized what they were up against and, rather than try to help Dale further, they clearly acknowledged how stressful and complicated her life was (which was true)

and suggested that it might be reasonable for her, in view of her life circumstances, to expect to have to attend two or more groups in order to reach her goal (joining her pessimism). Consequently, it seemed to make sense for her to lower her expectations and set a homework goal that she could fulfill. The leaders decided that setting aside a total of 10 minutes a day for herself would be a sufficiently difficult task. Finding enough time to masturbate to orgasm was clearly out of the question for the moment. (In other words, the therapists prescribed the symptom of not doing the homework.) Dale felt this solution was going a bit overboard and thought she could find a half hour. The therapists replied that it would be fine if she could find that much time but cautioned her not to pressure herself. She should aim for 10 minutes and any time beyond that would be fantastic but understandably very difficult to accomplish. Dale responded by being relieved but somewhat miffed. In the following session, she reported having found a little time to practice masturbation, was reinforced for doing so by the therapist, and again was advised to spend a much shorter time with the homework than the prescribed hour—perhaps 15 minutes daily. This time, she found an even longer period in which to practice and was rewarded by having an orgasm.

Mary always did the opposite of whatever the therapists suggested. She became orgasmic with masturbation in the sixth session, once the therapists discontinued assigning her specific homework tasks (abdication). Later in the group, when some of the women were given the assignment of practicing masturbation with candles and other phallic-shaped objects inside the vagina to pave the way for orgasm during intercourse, Mary suddenly developed vaginismus, a tightening of the muscles surrounding the vaginal opening that prevents penetration. Consequently, she could not insert an object to masturbate with. The therapists instructed her to take a vacation from homework which was exactly what she had been doing (paradox). Accordingly, Mary made considerable progress before the next session and experienced no difficulty inserting a candle. The therapists never asked how she managed to do the homework for fear she would begin to resist them again.

Once the strategy of abdication or paradox is employed successfully, it is important not to assume a more interested or supportive approach. There is nothing more inviting than a woman who has made a breakthrough after sessions of being stuck. However, if at this time the therapist attempts to "help" the client, especially by telling her what to do, resistance will arise again. It is essential to maintain the approach which has produced the positive results.

Some therapists do not like to use paradox because they deem it manipulative or dishonest. On the contrary, telling a woman to do something she already is doing gives her the opportunity to monitor her behavior closely and hence to gain control over it. My expecting little because the woman has accomplished so little is a reality. My giving up in defeat is reasonable. She can beat me hands down. She has control over her body; I have none. So, the therapist can either fight the client's resistance or use the power of the resistance to help attain the goal.

Some clients will refuse to carry out a paradoxical assignment. At this point many therapists are at a loss; they do not know how to present the paradox in a way that would make it acceptable. The following transcript illustrates a situation in which a client initially rejects such an assignment.

Abby: What I'm experiencing, and you picked it up, is the feeling that it's not gonna work, but I'll keep trying. I've had to be in the city every day and I just haven't felt like masturbating, but I know I could have found the time if I wanted to, if it had been top priority. So what I think I'm doing is repeating an old pattern of not following through.

Beverly: I have been doing the same thing and behind that is the fear that I'm not going to be successful. I'm really trying to shake that fear.

Therapist: Abby, I'd like to give you a different kind of assignment because I think there is a good reason for you to be exactly where you are now. There may be something important to learn from the doubts you have before we throw them away. What I'd like you to do rather than go home and try to do the homework and fight the tendency not to do it is to go home and get in touch with what it is going to be like for you to never have an orgasm.

Abby: I've done that.

Therapist: How much time did you spend on that?

Abby: How much time? I could get into it right now. What it would feel like to me would be that a part of me would stay dead. About not realizing my own potential as a person.

Therapist: But what would it feel like? Would you close your eyes for just a second? Imagine yourself getting older, going through the years. Visualize yourself getting older. Imagine what is going on in your life. Imagine yourself not having orgasms. Getting older and still not having orgasms. What is it like?

[Silence]

Abby: I see two things. I feel one part of me is very used to being like that. It is a comfortable way to be. It doesn't feel bad because I don't have the other side of it to know how good it could be.

Therapist: So it is comforting. Maybe that is how your life is going to be for you.

Abby: Ooooh. I don't want to live through that part of me.

Therapist: I think it is important to get in touch with the fact that that is the way your life is going to be. Has that not been true for you up until now? Is there a part of you that puts a lid on things you feel uncomfortable about or is it just in sex?

Abby: Sure, but that is not comfortable either.

Therapist: I would still like you to go home and, even if you are going to still do the masturbation, really get in touch with that comfortable part of you and acknowledge it. This is very important because this is a very important part of you.

Abby: I could say I was willing to do that, but that would mean cutting off a part of me that doesn't need to be cut off. What I may be saying is that I don't find it very helpful to be told that that is maybe the way I'm going to live my life.

Therapist: And my feeling is that that is a real possibility and it is really important for you to look at it because there is a very strong force here. I think that if you just say, "No, it's not there," and avoid it, it keeps creeping in.

Abby: In other words, I have to face the enemy?

Therapist: What I'm saying is that for where you are right now, you need to face that side of you and just to pretend that it is not there and you are just going to be the other way is not working very well.

Abby: Yes, but it is too easy to slip into that way because it is what I've done all these years. I've worked too hard at it and thought about it too long to do that. I've been hopeful all my life that it was going to happen.

Therapist: And you can keep being hopeful until the end. There is a state called being hopeful and you can just continue to be hopeful. And it will be very upsetting for you to think about what I'm telling you to think about. You've ignored it and pretended it wasn't there. It's very strong and being hopeful won't make it go away.

Abby: It seems I've made the choice, but I keep going back and forth. Maybe I don't stay with one or the other long enough.

Therapist: Well, that would be my homework assignment for you.

Abby: To go home and fantasize what it would be like to never have an orgasm?

Therapist: To experience that side, to really feel what that side is like. Obviously, you can do for your homework whatever you want to do, but that is what I would assign you to do.

CONFRONTING FEARS

If a woman is not resistant but is overly fearful, I generally become more confrontational after the initial sessions. I encourage her to note the feelings that pass over her as she completes the assignments. In the sessions I may spend considerable time working with her in an attempt to isolate and identify the

fears and personality dynamics that might be tied to the orgasm so that we can focus on them in appropriate future assignments.

Carla consistently did very little of her homework. She appeared very shy and naive about sex. She had had two lovers in her 45 years, to one of whom she was married for 15 years. She was now considering marrying the other man. Because of her discomfort in discussing sex, I took a supportive role with her until the fifth session. Since I was quite sure that her withholding was not an expression of resistance but of fearfulness, I then took a more directive role, again explaining the importance of the homework and giving her a vibrator to try. (She had been too anxious to buy one herself.) Within a couple of sessions she was orgasmic with the vibrator. In the last session she told me she felt I should have been more directive earlier and that I should force all the women to get vibrators and stress the importance of doing the homework more heavily.

Areas and issues that may require confrontation commonly include, but are not limited to, failure to express anger and sadness, lack of assertiveness, aversion to sex, as well as other psychological issues discussed throughout this chapter.

Individualizing the Homework

The middle sessions are characterized by individualized homework assignments. For the homework to be effective, there must be a specific reason for making each and every assignment. If a woman is failing to progress, it is sometimes better to make no assignment at all or one that has no goal other than to allow the woman to observe or monitor the process that is causing her difficulty.

Beyond the first four sessions, there is no preordained order to the homework assignments, and no one assignment is mandatory. A creative sex therapist could, with the help of the client, devise a potentially unlimited number of assignments to fit any particular problem. The concept of designing small steps toward reaching a goal rather than developing a list of specific exercises is important here.

Small steps and safety are the keys to tailoring the homework. Small steps means breaking down a goal into a number of subgoals. Safety refers to the physical and psychological components that enable the woman to feel secure and in control in the learning process. Small steps can take the form of

variations in duration, activity or setting, and intensity. For example, I may instruct a preorgasmic woman to masturbate for only five minutes daily at first, expanding the time until she is comfortable masturbating for an hour or longer (increase in time). She may begin with gentle manual masturbation and increase the speed and intensity of her touch or incorporate a vibrator (increase in intensity). Once she is orgasmic alone the next step might be for her to masturbate with a partner present but not participating in the actual stimulation initially (change in setting).

The individual woman needs to be consulted in order for the group leader to determine which small steps are appropriate with which safety measures. The therapist should ask questions to help ascertain the woman's fears or other problems in relation to a particular goal so that she can participate in designing the appropriate homework. The right approach to the solution of any problem is the one the woman feels is best suited to her own needs. The therapist helps isolate the problem, but the woman herself solves it—with some monitoring from the therapist.

Suppose a woman has become reliably orgasmic with masturbation and now wants to experience orgasm with her partner. The successful experience thus far has been her pleasuring herself in a certain manner while alone. The jump from this step to trying to have orgasms during intercourse would be too large for most women and might easily lead to failure. Therefore, taking what works (masturbation) and putting it in a new setting (adding a partner) is a reasonable first step. How the woman feels about this assignment will determine exactly how the homework should be designed; she and the therapist will pay special attention to what safety measures need to be employed.

Let us say that a woman is very fearful of looking ugly and thus disgusting her partner when she has an orgasm. For this woman, masturbating to orgasm in front of a partner would be too large a first step. The therapist and the client together can break this task down into a number of substeps. For instance, if the woman indicated that she would feel more relaxed if her partner were not watching her when she had an orgasm, I might suggest that she begin by masturbating with him outside the room but aware that she is masturbating. Perhaps she would prefer to have him in the room but with his back to her while she masturbates. Given that the woman's major concern is her appearance at orgasm, I might add the instruction that she masturbate but not have an orgasm the first time, as a way to maximize her sense of safety and comfort. Once she has succeeded in masturbating with her partner in the same room,

she may then feel ready to masturbate to orgasm with him looking at her.

LEARNING FROM FAILURE

If a subgoal is not attained through a particular homework assignment, this does not necessarily mean that the assignment is inappropriate. Important learning can result from an unsuccessful attempt at change if one can determine not only what does not work but also why it does not. The incident is frequently only one example of a typical pattern of handling certain areas inappropriately, and the so-called failure can help to point up the negative pattern quite clearly.

Grace could set aside only five or 10 minutes a day for her homework because of family obligations. She was thus unable to learn much about her sexual responsiveness. However, while telling the group about her difficulties in finding time for the homework, she realized that she had no time for herself because she put everyone else's needs before her own. This realization caused Grace to reevaluate her role in her family. Soon thereafter she decided that her needs were no less important than those of the other family members and began to set aside time for the homework.

DEALING WITH BLOCKS

Some women may be unable to carry out their assignments without first going through the desensitization process of practicing the homework in fantasy or role-playing it in the group. Again, take the example of a woman who is orgasmic on her own and desires to reach orgasm with a partner. When we talk about masturbating in front of her partner she becomes very anxious and says she could not possibly do it. Questioned further, she says she would have less difficulty doing such an exercise if her partner were to suggest it. Thus, it becomes more clear that the problem centers around her discomfort in initiating the exercise with her partner, not in actually doing it. The appropriate first assignment might be to have her practice initiating the exercise with a group member who is pretending to be her partner or to imagine the sequence of events in fantasy.

The homework assignments deal with the physical and mental components of sexual arousal. Other intrapsychic or interactional issues, however, are sometimes linked to orgasm and have to be resolved or considered separately from the sexual problem before orgasm can be attained (see pp. 159-

166). Homework assignments can be designed to help resolve such issues as well so that the path can be cleared to work on orgasm.[2] In some cases the nonsexual problems are so severe or persistent that the woman must attend a second (or third) group or seek therapy for the other issues before tackling her sexuality.

Homework assignments are designed to overcome particular blocks to experiencing orgasm. Common points in the arousal process at which blocks occur are lack of arousal, intermediate arousal, and high arousal with no release.

LACK OF AROUSAL

Many women report feeling bored, embarrassed, or foolish when beginning to masturbate. For some, this reaction is merely a stage in the process, and with the aid of fantasy or pornography (see Chapter 5) they soon learn to arouse themselves. Many others, however, lack perseverance and after a number of unsuccessful attempts feel both frustrated and helpless.

Vibrators

The use of a vibrator often enables such women to get over the hurdle of boredom and frustration. Using a vibrator, which supplies effective stimulation, is frequently also the easiest way for a woman to experience her first orgasm.

Vibrators are often discussed during the first few sessions either because a woman has heard about them and wonders about their effectiveness or because she is already orgasmic with a vibrator but not with other types of stimulation. Many women worry that vibrators are addictive or can decrease one's responsiveness to a partner. For many women the vibrator offers a quick and effortless route to orgasm, and some prefer to use a vibrator when they masturbate and even during partner sex. In this sense, a vibrator is no more addictive than enjoyable sex: it feels good and the procedure is consequently repeated.

Women who learn to have orgasms using a vibrator become accustomed to attaining orgasm very quickly, but the type of stimulation afforded by a mechanical device is significantly different from that

afforded by a human being. Consequently, learning to reach orgasm through manual self- or partner stimulation may be as time- consuming initially as becoming orgasmic for the first time. However, because of their previous effortless experiences, women who have used vibrators successfully tend to be more impatient and more easily discouraged and frustrated with manual stimulation than women who have never had an orgasm. It is important, therefore, to assign preorgasmic women the use of a vibrator early in the group— no later than the fifth or sixth session—so as to leave ample time before the group terminates to provide the continued support necessary to learn to achieve the orgasmic response with non-mechanical stimulation.

Some few women are orgasmic with a vibrator but are unable to respond orgasmically to any other type of sexual stimulation. I believe it is important to inform group members that this outcome has occurred. They then have the option to choose orgasm with a vibrator over no orgasm at all. And until there is evidence that vibrators cause physical harm, there does not seem to be any cause for concern about their use. Women who are pregnant or who have medical problems should, however, consult a physician before using a vibrator.

My concern about assigning the vibrator initially is that some women may use it as a way to avoid touching their genitals, especially when discomfort in touching their own genitals is related to discomfort in having a partner touch them. Accordingly, I explicitly address the issues involved and suggest that the women use the vibrator over their hands or that they alternate using the vibrator and a hand, whichever is more comfortable.

> Beverly: Where do you go to get all these vibrators?
>
> Pamela: I got mine in New York.
>
> Jenny: Drugstores. I ask for a body massager.
>
> Josephine: The one I got has a rubber tip. I got it through a place in Los Angeles. They had a table where they displayed a number of different kinds.
>
> Pamela: You can send for them.
>
> Therapist: How many of you have orgasms with the vibrator?
>
> Jenny: I have. I went for a lecture by Betty Dodson, at a women's workshop. She had a stainless steel one that was wonderful. I started thinking that if I got involved with a vibrator, it is such a gross sensation, just massive, it

might not be good. I was told by someone to stay away from the vibrator if at all possible.

Beverly: Because you might become dependent upon it?

Jenny: It's not that I would become dependent. It is just that it is not what generally happens with an outside stimulus. It is a more subtle thing if you use your hand.

Abby: Have you experienced sensations from your hand?

Jenny: I can do both. I feel different with the vibrator.

Therapist: All orgasms are different, from morning until evening and from day to day.

Pamela: How long does it take you with the vibrator?

Jenny: I can't give you the time, but sometimes it takes as long with the vibrator as it does with my hand. The vibrator is no guarantee that it is going to be quick. Sometimes it is.

Pamela: I felt like a vibrator was a little more painful or too intense. But then I thought, "Maybe if I could just start having orgasms with the vibrator." It is that initial awakening or whatever.

Maria: For me, the vibrator is easier than with my hands because it seems as if it's something else or someone else. It's not me doing it, so that takes away some of the guilt that I have. Because it's the vibrator that's doing it to me.

Therapist: And if it were you doing it?

Maria: Then I would be doing it, and I can't take that.

Therapist: Because?

Maria: Probably the same way as I feel about looking at my vagina. I think there's something about touching it that's, it's just that, I don't know. It's just—I can't touch it.

Many women are reluctant to purchase a vibrator even though they are sold in the small appliances section of most department stores. Frequently, overcoming the embarrassment and buying a vibrator, alone or with a lover or friend, is an important step. However, sometimes I lend a vibrator to a woman who is indigent or very fearful. Of course, vibrators can be ordered through the mail,[3] but the process generally takes longer than the time available to the group.

Most physiologically sound women will become aroused by vibrator stimulation. However, a particular woman may have to try a few different types of vibrators before she finds one that meets her needs. Some women seem to require intense vibrator stimulation; others prefer milder stimulation. The Prelude vibrator, designed specifically for sexual use, is one of the few electric models that has two

different intensities and a special attachment for clitoral stimulation.

Some women do not enjoy vibrator stimulation. However, if a woman who is not averse to their use has tried a few models without success or if she typically requires more than a half hour of direct genital stimulation with a vibrator to reach orgasm, her problem is likely to be an inability to concentrate. The additional assignment of fantasy or pornography will generally resolve her difficulty. If fantasy or pornography also proves unsuccessful, psychological issues related to orgasm may be at work. A woman who resists by withholding and who is likely to try to prove the therapist wrong should not be given the assignment to use a vibrator. If the issue of vibrators arises, it is generally best to present this method as likely to fail in her particular case.

Clare was the epitome of a woman who resists by withholding. She complained in the middle sessions that she found masturbation so boring that she preferred to be in the library studying. She was separated from her husband so masturbating with him was out of the question, and since she did not feel comfortable enough yet with her new lover to tell him about the group or her problem with orgasm, it appeared that Clare had all routes to attaining orgasm blocked. A vibrator was the only hope, but I knew that if I suggested it, she would find a way to dismiss that possibility also. So I told her, "Clare, I'm really stuck. I know that you find the masturbation assignments boring and doing it alone doesn't turn you on. I can understand that you don't want to try it with your husband since you're separated. You could try the vibrator, but that probably wouldn't work. And I can understand why you might not be comfortable enough yet with Paul to try it with him. I don't know what you should do." Clare decided that the vibrator made the most sense. At the next session she arrived looking quite different. Her hair had been cut and styled and she was dressed in a skirt instead of her usual jeans. She did not say a word and I refrained from asking about her homework. After the session had officially ended, one of the group members asked Clare what had happened with the vibrator. She matter-of-factly replied that she not only was having orgasms regularly with the vibrator but had almost had an orgasm when her husband stimulated her manually.

There is no reason for a woman who is orgasmic only with a vibrator to feel she has a problem unless she wishes to respond to other types of stimulation as well. When teaching women to transfer having an orgasm from the vibrator to the hand, take care not to indicate that there is anything wrong

with the use of a vibrator or with orgasms experienced in that way. All sexual successes are important. If either the leader or the woman herself treats the vibrator as a last resort, to be used only if she fails the "real way," the woman might end the treatment program reliably orgasmic with a vibrator but still feeling like a failure. However, if orgasm resulting from vibrator stimulation is perceived as a positive outcome, the same woman could from a position of strength work on enlarging her options if she wanted to do so.

Myrna learned after the second group session that her husband of six months was having an affair and desired a separation. She was very upset but wanted to continue the group anyway. After the fifth session Myrna became orgasmic using a vibrator. She wished to become orgasmic manually as well but felt her current crisis was interfering with her ability to relax and concentrate on more subtle stimulation. Consequently, she decided to defer that learning until she felt less distracted.

Women who enter the group orgasmic only with a vibrator generally wish to become orgasmic with other sources of stimulation. Initially I prohibited the use of a vibrator for the duration of the program to encourage such women to do the manual assignments more diligently. This approach backfired. Some women perceived the prohibition as deprivation and either continued to use a vibrator surreptitiously and felt guilty or followed the instruction and failed to progress because they resented being deprived.

Since then I have found several methods to teach women who are orgasmic with vibrators to reach orgasm in other ways. I have the women experiment with integrating manual and vibrator homework to see which combinations work best for them. One solution is to separate vibrator and manual masturbation assignments. The woman can use a vibrator one day and her hand the next or begin with her hand and use a vibrator after a specified period of time. (This approach needs careful supervision because some women get almost to the point of orgasm and then use the vibrator and wonder why they cannot have orgasms through manual stimulation.) Some women find that starting with the vibrator helps to turn them on; they then discontinue its use and build arousal with the hand. Others find the vibrator numbs them so that they are insensitive to later manual touching.

Another approach is to reduce the intensity of vibrator stimulation by having the woman place a towel or her hand between the vibrator and her genitals or use the vibrator in a more gentle, teasing fashion while intermittently providing manual stimulation. This procedure slows down the arousal

process and enables the woman to become accustomed to taking longer to reach orgasm with less discouragement. (Although reaching orgasm is taking longer, the woman anticipates success because of her prior positive experiences with a vibrator.)

Most women can transfer the orgasm from mechanical to manual stimulation if they put in enough time and effort. However, during the course of the group, some women realize that they are unwilling to expend the energy to learn to have orgasms in other ways and as a result accept the vibrator more completely. By the sixth or seventh session I encourage these women to use the vibrator with a partner if they are not already doing so. My goal is not to wean them from the vibrator but to give them permission to use whatever techniques prove to be satisfying. A woman who is satisfied using a vibrator alone and with a partner is limited only by electrical sources and batteries. If her partner does not mind or enjoys the vibrator, this outcome may be perfectly acceptable.

Some women use vibrators as a weapon against their partners, saying, as it were, "The vibrator can do it, but you can't." Often, such a woman is reluctant to become orgasmic using her hands for fear that she will have to be orgasmic when her partner stimulates her manually. Because of her dissatisfaction with the relationship, she is invested in withholding sexually. I reassure her that she probably will not lose her ability to withhold orgasm during partner sex: she has become too proficient at it. I bring up this point to show the woman that she is making choices and that she is not "inadequate." Of course, conjoint sex or marital counseling would be in order if both the woman and her partner were willing to participate.

Withholding

The topic of resistant women, those who feel their only power is to withhold, has been discussed throughout the book (specifically on pp. 137-144). I bring it up again here because withholding is probably the most common dynamic involved when women say they feel little or no sexual arousal. These women either do very little of the homework or, being "good girls," do absolutely all the assignments, but in neither case do they "own" the process.

Joyce, age 28 and married five years with two children, did the homework regularly but felt nothing. When we tried to pin her down on details she gave evasive answers. After three frustrating

sessions of little progress, we told her that we had no other information to give her; she was just different from everyone else we had worked with. Consequently, she would have to design a program to fit her individual needs and then perhaps we could learn from her. Joyce was angry and totally taken aback by this suggestion. However, after a few more sessions of receiving no assistance or instruction, she began to report progress. She had discovered some massaging techniques that were working for her. We continued to claim ignorance as well as amazement at her ability to design her own program creatively, and after another session she experienced her first orgasm.

Anxiety

Fearful of being overwhelmed by the anticipated intensity of orgasm, some women initially feel very little sexually when they masturbate. Usually this anxiety response first presents itself when the woman feels intense sexual feelings during masturbation (often by using a vibrator or running water over her genitals), at which time her fear of losing control causes her to cut off her experience of these feelings. Such women must be instructed to slow down and begin again very gradually. A temporary vacation from the homework may produce a sense of safety. When the woman starts doing the assignments again, she should try to feel only mild sensations and slowly build on these. After such a scare, experience has shown that it is realistic to suggest that more than one group may be necessary for her to reach orgasm. In general, very gradual desensitization works best with highly anxious women; pressure to move quickly to orgasm may retard progress.

Gerri knew that masturbation might help her experience orgasm but was unable to accomplish this goal herself so she joined a group in the hope that therapy would assist her. Initially, she felt very little sensation from masturbating manually. Then another woman in the group discovered that stimulation by water flowing from the bathtub faucet resulted in orgasm, so Gerri decided to try this technique. The first time she tried it she experienced very intense sensations and panicked. She felt that she was going to explode. After a couple of days she forced herself to try again but felt nothing. The next few times she tried she continued to feel only very mild sensations. We discussed her fears in the group and assured her that she was obviously capable of having the feelings; in fact, her tremendous sensitivity was creating some of her problem, and we suggested that she slow the process down. She took a vacation from the homework for a few nights and then began again, using her hand. By the end of the group she was able

to tolerate mild sensations. It was not until the middle of a second group that she was able to experience orgasm.

Including the Partner

Occasionally a woman is totally unable to arouse herself when doing the homework alone but experiences considerable body and genital sensations while making love with a partner. Such a woman may benefit from doing the homework with a partner present, and the therapist should help work out ways of integrating the assignments into the relationship. The difficulty is that the woman may curtail her own pleasuring by concentrating on her partner instead should she become uncomfortable with the intensity of her sexual feelings.

Phyllis was unable to turn herself on by masturbating alone. She did not fantasize easily, and pornography was unacceptable to her. However, she always felt aroused when she had sex with her husband and felt perfectly uninhibited in bed with him. When I asked whether she might prefer to do the homework with him present she was overwhelmed with relief. Asked how she would do the assignment, she said masturbating with him kissing her lips and breasts felt comfortable. The assignment to masturbate with her partner in this way seemed reasonable to me as well. If after a few sessions it had worked out poorly because of relationship problems or unexpected discomfort on the part of Phyllis or her partner, we would have had to devise another approach. Returning to solitary masturbation might have worked once she realized that she harbored a fantasy that her husband would do it for her. But in this instance, she felt good about the homework sessions with her husband and after a number of trials Phyllis experienced her first orgasm.

INTERMEDIATE AROUSAL

Once sexual sensations have begun to build, certain techniques can be used to enhance them.

Muscle Tension

Since the physiological components of sexual arousal are vasocongestion and myotonia (muscular tension), the buildup of muscular tension is important in attaining orgasm. Some women require more

muscular tension and find that crossing their legs, squeezing their thighs together, or practicing the Kegel exercises while masturbating helps to increase their level of arousal.

Other women build up too much muscular tension. They become overly aroused and must reduce the tension before they can experience orgasm. A brief rest or a short walk around the house may help. One woman claimed that getting up and brushing her teeth solved the problem. Sometimes pelvic bounces prove effective. This exercise requires the woman to lie on her back with her legs drawn up and feet placed on the surface next to the buttocks. In this position it is easy to raise the buttocks a short distance and then drop them on the surface again in a fairly rapid bouncing motion. A series of such bounces may reduce the tension sufficiently to allow orgasmic release when clitoral stimulation is resumed.

Relaxation exercises also can reduce pelvic tension. The woman should breathe deeply while visualizing that the air she is breathing is going in and out of the vagina. With each breath she can imagine the warm air relaxing the tension in the pelvic region.

Breathing

Breathing patterns are important in the sexual arousal process. Some women are breath holders: they stop breathing as tension mounts and orgasm draws near. Others are panters and take many shallow rapid breaths as arousal increases. Others find that slow, deep breaths increase sexual sensations. Having women pay attention to their breathing and experiment to see which breathing techniques seem most effective in building sexual arousal is advisable (see Rosenberg, 1973).

Miscellaneous Techniques

Some women find that moaning, grunting or talking enhances the arousal process. Others are distracted by sounds and prefer to remain silent. Moving the body, particularly the pelvic area, can foster the arousal process for some women; others need to lie perfectly still as orgasm approaches. Each woman is unique, and should be encouraged to experiment with each of these techniques, one at a time, to determine which heighten her sexual pleasure.

HIGH AROUSAL WITHOUT RELEASE

After learning to arouse themselves sexually, some women reach a high level of excitement but do not experience the release of orgasm. Frequently they report feeling frustrated, nervous, and uncomfortable after such episodes. Several techniques can help women to get beyond this plateau stage.[4]

Desensitization

A process of desensitization may be useful for women who become fearful as sexual feelings mount. The preferred technique is sometimes called "teasing" because the woman builds up to a high level of tension and then allows the tension to subside a bit by changing or stopping the stimulation; she then builds to a slightly higher level of arousal, stops, and repeats the process once more. During the next homework session she can begin by increasing the stimulation, beginning at the highest level of arousal she attained in the previous session. This method enables the woman gradually to become more and more comfortable with intense sexual sensations while still feeling that she is in control.

Role-playing

Acting out the most intense orgasm they can imagine is a productive assignment for women who reach high levels of arousal but cannot go over the top to orgasm. I generally instruct such women during the group session to imagine the most extreme orgasm they could have. We then discuss the most frightening aspects of the imagined orgasm and design safety measures to protect the women when they carry out the assignment at home. For example, if a woman is afraid she might scream so loudly that she would wake her neighbors, she could turn the radio up or put a towel or sock in her mouth to muffle the noise. If she is afraid that she would writhe around so much she might fall off the bed and injure herself, she could masturbate on the floor. If she is afraid she would urinate, she could masturbate in the bathtub or put a plastic sheet or towels underneath her on the bed. If she is afraid she would lose consciousness, she might call a friend or another group member before beginning the homework, instructing the person to come to her house if she did not call back within an hour.

Some women find that role-playing an intense orgasm causes the fabricated orgasm to turn into a real one. Others never fulfill the assignment and yet experience orgasm by the next session; just talking

about their fears is sufficient. For others, the role-playing seems to make no difference whatsoever; they continue to be stuck at the plateau level of arousal.

Maria: It gets me so mad, walking around with the level of tension that I feel at that point, and I just walk away from it like—bing. It's like building up to such a crescendo—you know my fear of looking epileptic; I think I'm going to be epileptic.

[Laughter]

Therapist: Is that what your fear is, that you'll be epileptic?

Maria: Right. At the point of orgasm.

Therapist: I'd like to have you try something, okay? With the homework, as you are feeling a little bit turned on, I'd like you to role-play an epileptic orgasm. I want you to get used to whatever that fantasy is. I want you to act out all those things that you think will happen. Okay? And still don't have an orgasm.

Maria: I know I'm going to feel silly doing that.

Therapist: Okay. Feel silly. Be aware of all the feelings that you have. But do it anyway.

Maria: I just noticed how desperate I get like when I'm with Bob: "Don't look ridiculous, don't look desperate, or he'll be scared and run away."

Therapist: Do all of that with masturbation. Okay?

Maria: Oh, God.

Therapist: That's a tough one for you. If it's too soon, then wait another session before you do it. But I think that that is going to be important for you to at least get a sense of letting go of that. You won't let go of that until you really can experience it and see what it's like.

Assuming Responsibility

In some cases the woman needs to realize that no one can make it easy for her to reach orgasm; she has to take a risk. This may require a leap of faith that no harm will come to her, or it may mean that she will just have to fight the fear and continue the stimulation, even beyond an hour, with the knowledge that no woman has ever died from attaining orgasm. It is sometimes helpful to tell the woman that it is important that she not lose control. In fact, she should understand that the object is to gain control—to have enough control to relax and go with her feelings.

Reducing Pressure

Sometimes the paradoxical injunction of telling the woman to take a vacation for a few days results in her attaining orgasm. Some resistant women may oppose the therapist's suggestions by having an orgasm when told to take a rest. Other women feel more freedom to respond once the pressure to perform has been removed.

The issue of performance pressure in preorgasmic groups is complex. Masters and Johnson (1970) successfully operate under the assumption that the pressure to perform is one of the most common causes of sexual dysfunction, and one primary aspect of their therapy is to remove this pressure. In the preorgasmic groups, pressure to perform can be created by group competition if the leaders are not careful. Since orgasm is the natural result of the buildup of pleasure, one successful way of reducing performance pressure is to change from a goal orientation of focusing on orgasm to a process orientation of experiencing more and more pleasure: emphasize pleasure and deemphasize orgasm.

Misidentification

Some women who claim they are only reaching high levels of arousal are in fact having orgasms. They resist labeling them as such because the orgasm they experience is different from what they expected.

By the eighth session, Kelly, who had come into the group clinically depressed, was feeling better and even looking physically healthier. She was enjoying her homework and claiming that each homework session was better than the last. She expected that orgasm was not too far away but was not concerned because all the exercises were so pleasurable. Since I could not tell where she was stuck or why she was not yet having orgasms I doggedly inquired into the most minute details of her homework sessions. She described her feelings as going up the shaft of an umbrella and then spreading out over the top of it as if the umbrella had opened up, after which she felt relaxed and warm all over.

Her account sounded like a classical description of orgasm, but when I told her so she vehemently disagreed; it did not fit her husband's description of what he experienced when he had an orgasm. Suddenly it became crystal clear: her expectations were creating the problem. Even after I explained that

men's and women's orgasms are different Kelly resisted labeling her experience as orgasm. In the ninth session she came in and reported having had three more of "those things you call my orgasms." By the tenth session she, too, was calling them orgasms and seemed very satisfied with her progress.

Psychological Interferences and Relationship Problems

Though I believe that the fear of loss of control is the central dynamic among women who are preorgasmic, I do not adhere to the Freudian notion that anorgasmia is necessarily a symptom of underlying psychological distress. In some women, however, the attainment of orgasm is "hooked," or tied, to another psychological issue or conflict. But even in these cases, it is rarely essential to resolve the deeper psychological problem in order for the woman to attain orgasm. Determining the connection between the issue and the orgasm and then disconnecting the two frequently enables the woman to experience orgasm, although additional therapy may be required for resolution of the deeper problem. Often, the therapist cannot tell that a woman has a problem tied to orgasm until the sixth or seventh session, when diverse approaches have been unsuccessful. The following pages contain examples of some deeper issues that are frequently connected to attaining orgasm.

Expectations of Life Changes

Many women come into the groups expecting that when they become orgasmic their lives will change dramatically. Their belief is that orgasm will bring relief from all their daily problems and struggles and that once they are orgasmic they will become adequate in all the ways in which they feel they are currently lacking.

At first glance, this attachment between orgasm and life change appears to be positive: since the women are looking forward to having their lives change, one would expect that their optimism would encourage the experiencing of orgasm. However, this simplified view overlooks the complexities of a life change. On the one hand, the women welcome the change; on the other, they fear it. If their lives were different, how would they be different? The problems they are currently experiencing may be annoying, but they are at least familiar and predictable. The unknown, even if it is expected to be better, is very anxiety producing. Consequently, as long as orgasm is linked to the unknown, fear of the unknown will

interfere with attainment of orgasm.

> Maria: I did cop out in not coming the last two sessions because I felt the group wasn't what I expected. I did expect more: with sexual orgasms and all I thought that personalities would change. I thought that's why I wasn't having orgasms. Because I expected a whole personality transformation and it never happened and I saw people who hadn't had orgasms were having orgasms and there was no personality change. I thought you become different and beautiful and everything's just so beautiful and there are no problems in the world. And that didn't happen and that let me down. I expected too much.
>
> Abby: See, I can say this because I know I was doing it, saying, "If only I could have an orgasm, my whole life would fall into place.'' And you'll scare any orgasm into the other direction. There's so much expectation laid on those little things.

It is essential to disconnect the prospect of life change from the attainment of orgasm.

> Therapist: What would be different if you had an orgasm?
>
> Beverly: I guess I'd feel more satisfaction as a woman. Completed. It won't make the other things that are happening in my life change at all, but it would make me more even, more tolerating.
>
> Abby: It isn't that much different. All the stuff is still there. At the time, you feel good. You think, "Hot dog," then the dog bites the postmaster, your mother calls up on the phone, and it's all there.
>
> Therapist: Satisfaction as a woman? What does that mean?
>
> Beverly: Well, whatever you're supposed to experience as a woman in life. I think that all the years when I didn't have, I was wondering if I was a frigid person. But I was told that I wasn't. I knew I wasn't frigid because my emotions were warm.
>
> Therapist: I see. So, this would be a total validation of Beverly. If you were orgasmic that means in some sense that you're okay. And other things wouldn't bother you as much because you could tolerate them . . . being orgasmic. ... You got a heavy load on this orgasm. How about other people, with your orgasms? Do they solve all your, or at least make you handle all your problems better? Don't you find that your other problems don't bother you because you have orgasms?

Although many women's lives do change once they become orgasmic, in that newfound control over their sexuality enables them to gain greater control over other aspects of their lives, I do not address this possibility. Rather, I explore how the woman expects her life to change: how will it be better and how may it be worse? Eliciting the negative is difficult since the women generally prefer to believe that only positive changes will result. Finally, having elicited all the specifics, I reframe the issues in order to debunk this myth. For example, I may say, "It certainly would be nice if having orgasms would improve your ability to get another job, but whether or not you have orgasms it sounds like you'll need some

further education or therapy to straighten out your job problems. Now, you can seek further education or therapy being orgasmic or seek it not being orgasmic—it's your choice."

Most women resist this interpretation, but it is important to stand firm. In the long run, it is better for group members to face possible disappointment initially than to have their expectations encouraged and not only have their nonsexual agendas unrealized, but have them interfere with their sexual progress as well.

Fear of Responsibility

Lorie believed that if she became orgasmic she would lose her adolescent freedom and be forced to become responsible, which to her meant getting married, a nine-to-five job, straight clothes, and boring colleagues. I sympathized with the dreariness of this prospect and reframed her concept of "responsible adult" by saying that I hoped I would not have to give up my orgasms to remain carefree and spontaneous. The other group members agreed: they did not want to grow up either if it meant fitting Lorie's concept of a responsible adult. Hence, we gave Lorie permission to continue to be totally irresponsible and orgasmic at the same time. She could wait years to grow up and become responsible, but she did not have to wait that long to enjoy orgasms.

Fear of Vulnerability

We did not recognize Brenda's situation at first. She kept talking about how much better she felt about herself since beginning the group—that the assignments were helping her progress from being very controlled and unemotional to being more open and vulnerable in general and particularly with her partner. She was delighted because this change was a goal for her. I did not recognize the problem until she told a story about walking in a rather seedy section of town and being greeted by an unshaven and disheveled man. If she were really open and vulnerable, she felt, she would have responded to him in a friendly manner, but she could not. She felt paralyzed. As she told this story I realized that being open and vulnerable was something Brenda both wanted and feared. So we talked about control and limits and how she could be a little more open without having to talk to everyone who walked down the street, but Brenda insisted that being totally open was her goal and through the help of the sexual

exercises she was on the right path; it just might take longer than the three sessions we had remaining in the group. I knew then that disconnecting orgasm from openness and vulnerability was essential so I replied, "I know that being totally open and vulnerable is a goal for you, and it is a valuable goal, but maybe, just maybe, by the time you are 65 you'll achieve total openness and vulnerability. Do you want to wait that long to be orgasmic?" Brenda began to cry. I was bursting her bubble of hope: she was so sure she was on the right track. I then gave her the homework assignment of exaggerating her feelings and her sadness to enable her better to comprehend the reality of the situation. She did not like what I had to say, but two sessions later she had had her first orgasm with her partner and by the 10-week follow-up was orgasmic about half the time with him. She was still not "totally open and vulnerable" but was feeling very positive about her progress.

Partner Related Difficulties

Problems in a woman's relationship with a partner are commonly hooked to orgasm. As I noted earlier, some women fear that if they become orgasmic on their own they will have to be orgasmic with a partner. If they are involved with someone they do not trust sufficiently to reach orgasm with, or if they are angry with their partner and view orgasm as a gift they do not want to give, they may resist becoming orgasmic. It is not uncommon for a woman to fear that if she becomes orgasmic her partner, even though he says he wants the change, will in fact be so threatened by the change that he will leave her. Such a woman fears that being orgasmic will make her more dependent upon a partner and that she would therefore be more devastated if the partner were to leave. Or, she might fear the opposite: if she becomes orgasmic she may discover that the relationship is no longer satisfactory for her.

In these situations it is important to separate the orgasm from the relationship issue. The therapist can reassure the woman that she will not lose her ability to hold back her orgasm with a partner if she desires to do so. I explain that it is impossible to avoid making changes in a relationship if it is to last; that if the woman looks back over the relationship she will find that changes have indeed been made without separation occurring; that she would probably be devastated if her partner left her whether or not she had orgasms with him but if she were orgasmic at least she would have a chance of experiencing orgasms with another partner; and that her fears of leaving her partner may have some basis in general dissatisfaction with the relationship—issues that may need to be addressed if the couple is to remain

together. Some women do feel more dissatisfied with their relationships once they become orgasmic, but this result may reflect a change in self-concept rather than any relationship change. Frequently, when women become orgasmic they feel less inadequate and consequently believe that they deserve more. A relationship that was satisfactory to someone who viewed herself as a sexual cripple and felt lucky to have any partner at all may not be acceptable to a woman who feels whole sexually.

Sally was recently separated from her husband but was uncertain whether she wanted a divorce. She had a lover with whom she enjoyed sex, although she never experienced orgasm with him. She did not feel at all turned on by her husband but thought of him as her best friend. The fact that they had a young son complicated the matter. After careful probing in the seventh session it came to light that Sally had the attainment of orgasm hooked to her decision regarding divorce. She believed that becoming orgasmic would bring back her sexual attraction to her husband; if it did not she would have to divorce him. Since she was not prepared to make this decision she was holding back sexually. Once I realized that orgasm was connected to divorce, I unhooked the issues by telling Sally that orgasm would definitely not have any effect on her feelings of sexual attraction toward her husband. She still would not be attracted to him and whether or not she became orgasmic she would have to make the decision about divorce quite independently. Sally seemed greatly relieved. Using a vibrator, she had an orgasm before the next session, came close to orgasm with manual stimulation by her husband, found him to be no more sexually attractive, but continued to put off the decision about divorce. (Three months later, they got back together and, to date, are still together. Sally did regain her sexual attraction to her husband—but then she experienced the opposite of everything I predicted.)

Unhooking the Hooks

Detaching orgasm from the issue, conflict, or wish to which it is hooked can be done in a number of ways. Pointing out the issue that is attached to orgasm and then carefully and logically disconnecting the two without discounting either the orgasm or the other issue can be very useful.

I also find it effective to reframe and to exaggerate the attachment until it reaches the level of absurdity. This approach was followed in Brenda's case when I pointed out that if becoming orgasmic meant being totally open and vulnerable she might have to wait until she was 65 to have an orgasm. In

Lorie's case I exaggerated the notion of being responsible to make it so uninviting that no one in her right mind would aspire to this goal. Reframing or exaggerating the attachment frequently brings disappointment and tears. I pursue this reaction because it seems reasonable to grieve over the loss of an important fantasy, especially when accepting reality may be the woman's only hope for real change.

Deeper Issues

Although from time to time deeper issues interfere with the attainment of orgasm, they are far less pervasive than we have been led to believe. However, certain negative psychological patterns sometimes must be worked through in order for orgasm to occur.

For example, some women have to get in touch with their sadness and anger before they can experience sexual feelings. Women who withhold all their emotions are likely to hold in sexual feelings as well. It is not uncommon for such a woman to experience her first orgasm after breaking down and crying or having an angry fight with her partner. Techniques to help the woman get in touch with these feelings are the same as those used with any general therapy client in a similar situation.

Pamela, although not orgasmic, was upon closer examination really not a sex therapy case. She described her genitals as being numb and frequently used a vibrator directly on her clitoris for an hour or longer until she felt pain. Pamela was also very depressed but felt no anger or sadness. I did not realize the extent of her problem until mid-group, at which time I decided that working on orgasm was inappropriate without first working on the expression of feelings. I explained to Pamela that her being cut off from her sexual feelings was only one aspect of a more general pattern, that I did not know how successful we would be within the context of the group, and that individual therapy might be required, after which she could work on orgasm in a second group. Pamela agreed. Afterward, I had her lie on the floor, fully clothed, on her back and invited the group members to massage her. This experience brought intense feelings to the fore: Pamela screamed and cried and bit into her fist. Subsequently, she began to take greater risks in relationships and became more aware of her feelings. By the tenth session, she had had an enjoyable sexual relationship in which she had experienced pleasurable feelings. By the three-month follow-up, I was amazed to learn that Pamela had continued with her masturbation assignments and for the previous two weeks had been orgasmic regularly with masturbation.

Group Norms

Each group takes on a life and personality of its own, and each group develops a unique set of norms, the underlying assumptions upon which the group process operates. Frequently, these norms are highly coercive and can either enhance or inhibit the group process. Positive norms—group cohesiveness, openness, and support, for example—facilitate the process of the group. Negative group norms obviously interfere with the success of group members. Yet negative norms are easily reversed, and often one or more women become orgasmic in the session after the one in which a negative group norm has been exposed.

Group norms are usually covert but everyone feels their presence and silently abides by them. These norms are difficult to determine because they are what the women are not talking about rather than what they are talking about. It requires skill in understanding group process to recognize and expose group norms. Usually, if no women have experienced orgasm by the sixth or seventh session, the therapist can look to a negative group norm as the cause. In some cases, the group leader can uncover the norm by noting what is not being expressed in the group as compared with topics and feelings usually discussed in preorgasmic groups. Likewise, she can use her own reactions in the group as a barometer to evaluate the process. Frequently, group members may be able to explain the lack of progress and clarify the issues that are at the root of the problem. However, such knowledge is often outside their immediate awareness, and having the leader point out that there seems to be a problem can help them attend to and verbalize heretofore unspoken and even unformulated feelings.

One of my groups was unusual in that group cohesiveness had not formed by the third session and I felt ill at ease and somewhat anxious running it. In the middle of the third session I asked the women how they felt about the group so far. Did they feel something was missing? One member asked whether they could bring cheese and crackers to eat at the next session; another wanted to sit on the floor. When I asked why they had not made those suggestions before, they answered that they had not realized they could—they were not sure of the rules. It appeared that a group norm of not transgressing unspoken rules had developed partly in response to my co-therapist, who had never run a group of this type before. Her uncertainty about the process seemed to be mirrored by the group members: everyone was being overly cautious and not investing herself in the process as the members would have had they felt

more secure. At the next session, two women brought cheese and crackers, another brought wine, and we sat on the floor. Everyone relaxed and group cohesiveness seemed to form instantly.

Leaving ten minutes at the end of each session for the women to express how they felt about the session, what they got out of it, and what was lacking or needs to be included in future sessions frequently prevents the development of negative group norms. Again, the concepts can be most clearly described through illustrative case histories. The following are some examples of how negative group norms have been isolated and reversed.

In the first research group I ran for my dissertation, I unintentionally created resistance by being too personally invested in the members' experiencing orgasm. At the time it seemed that my graduate degree depended on the success rate of the group. By the sixth session, progress was limited: two of the five members had had orgasms after the third session when instructed to masturbate but not to have an orgasm. One of these women failed to repeat the experience. Meanwhile, the group was enjoying heated discussions about their relationships with mothers, fathers, sisters, brothers and how these relationships related to their lack of orgasm. I kept trying to elicit homework details and wondered why no one seemed to be doing the assignments. After the sixth session, I consulted with my thesis supervisor, who commented that I seemed to be more invested in the homework and the orgasm than the group members were. Consequently, when no new orgasms were reported in the seventh session, I told the group what my supervisor had said, adding that I had done what I could and it was now up to them. The women knew what steps to take if they wanted to have orgasms, and I was going to shut up and let them run the group because I felt I was getting in the way of the process. They carried the group on by themselves and I listened. In the eighth session two women reported their first orgasm. In the ninth session the last woman became orgasmic, and the woman who had had only one orgasm had begun having more.

My second dissertation research group kept to the subject of orgasms and completed the homework religiously. But when two women failed to attend the sixth session, and no one had yet reported an orgasm, I knew that another negative group norm was operating. I had no idea what it was so I asked the group members what they thought the problem might be. They quietly began expressing discouragement and frustration, feelings that they had been afraid to bring up because of their expectation that the process was supposed to work. I then realized that in my relief at their dutiful homework participation,

so different from the previous group's laxity, I had colluded with the members' wish not to talk about all of their negative feelings. A group norm of "it's only okay to talk about successes" had developed. Accordingly, we spent the sixth session talking about depression, disappointment, and hopelessness. The homework assigned in that session was for the women to get in touch with the fact that they might never have orgasms. One woman angrily stomped out of the room saying that she had already waited 35 years to have an orgasm and was not going to think about waiting 35 years more. The next day she had an orgasm and the domino effect was in motion. The rest of the sessions proved clear sailing.

(My third dissertation research group went like clockwork: only positive group norms developed and one or two orgasms were reported at each of the sessions from the fifth through the ninth.)

Some group leaders consulted with me on a group that had experienced so much partner sabotage that the women could not complete their homework assignments and spent most of the group time talking about partner interference. It became clear to me that the leaders were unwittingly reinforcing the partner sabotage. The women had formed a man-hating group, with the leaders agreeing that their partners were responsible for the women's lack of success. The partner problem had become a form of resistance for the whole group. It was easier for the women to talk about how awful their partners were than to talk about how anxious they felt about doing the homework. Had the issue been raised and had each woman been given back the responsibility to find ways to complete her homework despite her partner, the group norm might have been reversed. The leaders might even have made group discussion of partner difficulties off limits since that topic was interfering with discussion of the masturbation homework.

In another situation, two therapists I supervised were so good that they helped the women not only with orgasm but with many of their other problems as well. However, an unusual process developed in the group. The women would come to the sessions reporting orgasms but complaining about their number, intensity, or some other characteristic. This kind of dissatisfaction had never been manifested in other groups. As we began to observe the process more closely, it became apparent that after making the initial sexual complaint, the women would direct the discussion to other areas of their lives and receive therapy for nonsexual difficulties. Even if sex were going well, they would find a sexual complaint in order to get the therapists' attention. The leaders had inadvertently connected orgasm to other life

problems, and a group norm of reporting sexual dissatisfaction in order to get assistance on other issues had developed. Once they recognized this pattern, the therapists could say, "You're doing fine sexually, but do you have any other areas you'd like to work on during this session?" thereby disconnecting sex from other problems. The women received the therapy they wanted, and their sexual complaints ceased.

In one group that I ran no orgasms had been reported by the seventh session. This group was very close and supportive, which led me to suspect that negative competition had developed. Women in this society frequently find it difficult to compete and succeed for fear of making those who are less successful feel bad. Obviously, if no one can win, no one can become orgasmic. So I asked, "Who do you think is going to be the first to have an orgasm?" Everyone immediately pointed to Barbara, the most gregarious member of the group. Barbara said, "Oh, no, not me!" and pointed to the others. I then commented that it looked as though we were going to be there for a long time if no one wanted to be first. The waiting game ended when one woman reported an orgasm at the next session.

Another situation involving negative competition arose when two women announced in the second session of their group that they had had orgasms. We were surprised to discover that despite their early success neither of them found time to complete the homework assignments for the second and third sessions. During the fourth session I noted how interesting it was that both these women had stopped doing their homework since they had become orgasmic. I suggested that for women success is often not a virtue and wondered whether perhaps they might be feeling uncomfortable about being so far ahead of the others. The session ended and no discussion followed, but both women came to the fifth session having had a few more orgasms.

Negative competition can inhibit progress in a group whereas positive competition can enhance the process. On one occasion I was training six therapists who were paired up as leaders of three groups. We all met together weekly in a group supervisory consultation. Two of the groups were moving along nicely; the third was doing spectacularly well, with all the group members orgasmic by the fifth session. I had never seen a group progress so rapidly, and we tried to figure out what the leaders were doing to obtain such rapid results. They could think of nothing except that after every consultation they told their group how much better they were doing than the other two groups. They had inadvertently set up a process of positive competition similar to that researched in the famous Robbers Caves experiment, which

showed that campers performed best and were most motivated to win contests when structured in such a way that they never personally competed against their opponents but instead received daily notice from the counselors indicating lower scores for the opposing campers (Sherif et al., 1961). This group had no losers: the losers were in the other groups and no one had to feel guilty about being more successful than anonymous opponents.

These are just a few examples of some group norms and the process employed in dealing with them. It is important to stress again that group norms are difficult to identify because they represent that which is unspoken. However, it is possible for the therapist, with the aid of the group members, to recognize the presence of a negative group norm, isolate it and reverse it thereby freeing the women to become orgasmic.

Attaining Orgasm

It is not uncommon for women who have had their first orgasm to come to the group looking different from the way they looked prior to the experience. Frequently, they have had their hair cut or styled; they may wear makeup to the group for the first time; or they may dress more carefully or in a different fashion. In most cases the woman looks more attractive, as if she is demonstrating that she feels better about herself and deserves to take greater pains with her appearance. It is always a genuine delight to see this transformation.

The first orgasm generally occurs between the fourth and the sixth session. Orgasms occurring earlier are unusual, especially since the homework to masturbate has not yet been assigned. If no woman has had an orgasm by the sixth session a negative group norm probably is in effect and there is reason to be concerned about the group process.

EARLY ORGASMS

Women who become orgasmic by the second or third session are generally those who require little more than a structured, supportive, and permission giving environment. The process of deciding to seek help and applying for group membership is sufficient to enable some women to masturbate to orgasm even before the first session.

Women who experience orgasm very early in the process are often embarrassed and reluctant to share their success with the group. One woman had an orgasm before the second session but did not tell the group until the third and even then was reluctant to do so. The concern of many women who are successful early is that the other group members consequently will dislike them. And, in fact, the other members frequently are jealous.

The real problem with early orgasms from the therapist's point of view is that the other group members may not have developed sufficient identification with the newly orgasmic woman to set off the chain reaction that is a crucial part of the process. The newly orgasmic woman was just like the others before she had her orgasm and she is no different now; her whole life has not changed, but she is having and enjoying orgasms. The other women begin to believe that perhaps orgasm is possible for them, too. For example, when June had her first orgasm she immediately telephoned another woman in her group with whom she had become friendly. The second woman had her first orgasm the same night. But the domino effect requires that group members identify with one another. When a woman becomes orgasmic too early in the process she is seen as being different from the others; they do not easily identify with her. Often, the impact of this first orgasm is insufficient to establish the necessary momentum. In this situation I attempt to promote identification by having the orgasmic woman describe in as great detail as possible any negative feelings, fears, and difficulties she may have had in regard to her first orgasmic experience.

ELICITING DETAILS

The first woman in the group to have an orgasm rarely reports it with certainty. Typically, first orgasms are mild in intensity and may differ from the woman's expectation. Furthermore, women are hesitant about building up hope that what they experienced was really an orgasm for fear they might be wrong. Finally, as previously mentioned, it is often difficult for a woman in a group situation to "win" by reaching orgasm first.

Because of the woman's difficulty in identifying her first orgasm, it is important to delve into the details of the masturbation experience. I usually get the most reliable clues if I ask the woman when she stopped masturbating and why. If she discontinued masturbating because it was the end of the hour, it is unlikely that orgasm occurred. However, if she stopped because she felt a buildup and then something

different, or had a sensation of warmth and relaxation, or just did not feel like going on anymore, especially if her clitoris felt very tender or sensitive afterwards, I can be fairly certain she experienced an orgasm. Most women also note contractions of the pubococcygeal muscle at orgasm. However, contrary to Kline-Graber and Graber, who contend that "these contractions are the hallmark of orgasms . . . without them, there has been no orgasm [1975:4]," I find that many orgasmic women either do not experience contractions or are not aware of them. The following excerpt illustrates the details sought to ascertain if a women is orgasmic.

> Josephine: I didn't have any real luck. One day I was masturbating so much that, I was using lotion, that my fingers kept getting all wrinkled. I thought, "Well, I guess I've tried long enough." I kept on trying.
>
> Therapist: Well, what happened?
>
> Josephine: It's just the same as usual.
>
> Therapist: Well, what's usual?
>
> Josephine: I get to a certain point and it seems like something's going on and then I kept masturbating past that, but nothing more happened. I don't know if I was more or less aroused afterwards.
>
> Therapist: Okay, you get to a point where something is happening. What do you mean by something is happening?
>
> Josephine: It feels like I'm almost at the point where I'm going to have an orgasm.
>
> Therapist: What does that point feel like?
>
> Josephine: I don't know. I'm really turned on and excited. How can I explain it to someone?
>
> Therapist: Well, try to explain it. What kinds of feelings are they? Would you give them a word like a tingling, buzzing? Where do you feel them? What's happening in your body? What's your breathing doing?
>
> Josephine: I feel mostly right on my clitoris and my vagina. I didn't get any tingle from it. Not sure about my breathing. I try to take short breaths and deep breaths.
>
> Therapist: Okay, so it doesn't matter much how you breathe. Does it feel like it's intense down there?
>
> Josephine: Yeah, a little.
>
> Therapist: Then what? Does it start feeling different after that or does it go dead or numb?
>
> Josephine: No, I don't feel dead. I still have a lot of sensations there, but I guess I feel like I want to stop for a while and rest. I just want to stop masturbating and rest. But this time I kept on trying after.

In no case can I determine conclusively that another woman has experienced an orgasm. Erring in either direction creates problems. If I mistakenly confirm a report, the woman may become confused and frustrated should she be unable to identify additional orgasms. I may then find myself near the last session with a woman who is bewildered and upset. If I fail to confirm an orgasm, the woman may be orgasmic while continuing to feel sexually inadequate. Consequently, if I think a woman has had an orgasm, I usually say that it "sounds like" an orgasm to me, but since we are not absolutely certain she should repeat the homework, paying special attention to the details. If an orgasm did occur, it is almost always repeated. If it did not, some "optimistic doubt" will often reduce the woman's anxiety about the experience of orgasm itself. If a woman thinks she has had an orgasm and her worst fears were not realized, generally she will be more relaxed and optimistic about future experiences. Many women claim, after they have had a clearly defined orgasm, that previously they had been experiencing "mini-orgasms."

When the first clearly identified orgasm is reported to the group, I generally prefer to let the group members question the woman.[5] Sometimes the group responds as if they are a bit shell-shocked and I have to initiate the discussion by commenting, "It's interesting that no one is particularly interested in [so-and-so's] orgasm." After the group has elicited the details from the woman, I may have to place her experience in perspective. If her orgasm was intense, I note that most first orgasms are fairly mild. If she reported any idiosyncratic body experiences (urinating, vibrating legs, hot feet, gasping for air), I point them out so that the other women do not expect to respond in an identical manner.

Once the orgasm has been thoroughly explored I always ask the other group members how they feel hearing that someone else has had an orgasm. The response is twofold. On the one hand, the women are hopeful: "If it could happen to her, maybe it could happen to me." On the other, they feel jealous or resentful: "Why couldn't it have been me?" Generally, only the positive feelings are expressed initially. If no one mentions negative feelings, I elicit them so that the women do not go home feeling secretly they are terrible or wicked for wishing ill toward someone who has experienced success. (The danger here, of course, if that guilt about ill wishes can create a sense of being personally undeserving of an orgasm.)

After the first orgasm has been experienced, the woman is instructed to continue the masturbation homework in order to learn more about this newfound process. Orgasm oriented partner homework is

not assigned until the woman is reliably orgasmic with masturbation.[6]

WOMEN SLOW TO REACH ORGASM

A number of approaches can be taken with a woman who has not experienced her first orgasm by the ninth session. The therapist ought first to understand why the woman is encountering difficulty in order to determine what future approach would be most effective. The therapist should remember that some withholding, resistant women become orgasmic in the month or two after the group has ended.

I may offer an eleventh session to a woman who has recently made significant headway and for whom orgasm does not appear to be too far off. She is free to refuse an additional session, but if she says yes, she can determine how much time she requires in the interim and then invite the other group members and the leaders to join her. (The women who wish to attend will have to pay for the extra meeting. The ten session program is very short and most women have sexual agendas, particularly regarding partner exercises, that they are working on. Thus, there may be considerable interest in a post-group session, which does not take the place of the regular follow-up.)

Another approach is to try to take the pressure off the woman. First, the therapist should discuss with her how it feels to be last—after all, someone has to be last. Second, she should instruct the woman to report at the following session that she has not had an orgasm whether or not she has. This tactic aims to protect the woman from group pressure to perform; women who then experience orgasm always enthusiastically disregard this instruction, as the following transcript, from a final session, demonstrates: Beverly was given the instruction in the ninth session to report no orgasm to the group at the next meeting.

> Beverly: I had an orgasm. At 3 P.M., reading Fanny Hill. I'm embarrassed a little. Everybody was very supportive last week. I was saying, "My God, I'm doing this like a text book. Doing this, doing the breathing." I listened to what everybody had said, "Do your homework and don't expect it." So I didn't. I started reading and doing—I'm still feeling quite as stimulated as I have on other occasions—but it's not going to happen and I thought, "But don't let it happen. Well, it's not going to happen anyway." I was having this conversation with myself. But, I will say that there's no doubt. I really didn't think it would be that sharp a sensation.
>
> Therapist: What was it like? Were you using your hands or a vibrator?
>
> Beverly: I was using a new vibrator but the position for me was different. It was the way Abby had described it: your legs up against the side of the bed, against the wall.

Abby: You put them up against the side of the bed or wall and you get resistance. When you're making love with somebody, try that.

Beverly: That's what I was doing and I was turning the pages. And kept more or less, more stimulated, and I thought, "No, no, no, turn it off, turn it off." And all of a sudden I felt a flooding and I thought to myself, "I hope this is different." This is different and I just put the book down.

Pamela: Where did you feel it?

Beverly: I felt it very definitely in the genital area. Very strongly. There was like an electric current all the way through up to my face. I felt it very strongly. I would say it was the way I anticipated it but didn't think it would be as uncontrollable. I thought that I would have control over it.

Therapist: Did that scare you?

Beverly: A little, but not enough to make me stop. I couldn't have stopped it really. You really couldn't stop it. It seemed to go on for a long time.

Abby: What happened with you and urinating? Did you do that?

Beverly: Yes, I told you before that I always did that. And what I did because I just didn't want to get up, I just turned over on the towel after I climaxed. I just let a few drops out. And then I thought, "Well, there was no doubt in my mind." So, then I thought, "Should I try it again? Don't press your luck." But I did.

Therapist: Now, what was the difference? What allowed it to happen this time and it hadn't in the past?

Beverly: I don't know. I have felt as close to it before. I have felt the pressure. I think the position made the difference.

Pamela: That's a real success story.

Therapist: That's wonderful. Just under the wire: 3:17 p.m. today.

Beverly: No, 3:10 p.m. to about 3:20 p.m.

LATE ORGASMS

I might be skeptical about a woman who is last or next to last to report experiencing a first orgasm, especially if her account is cloudy

176or if the woman is unsure. Group pressure is so strong that it is possible for a woman who feels no hope about attaining her goal to report success simply to gain acceptance and approval. Throughout the course of the therapy I make it clear that a woman is not a failure if the group process does not work for her within ten sessions. A second group or even an alternative form of therapy may be required for a

particular woman.

Notes

1 I learned from this error never to give any assignment to a whole group without considering its appropriateness for each individual.

2 Structured homework assignments have been so successful that I use this approach with all my psychotherapy clients. Once the concept of tailoring homework to fit a particular problem or situation is understood, it is quite simple to generalize the process to other issues.

3 Many vibrator models can be ordered through Eve's Garden, 119 West Fifty-seventh Street, New York, New York 10019. The Prelude vibrator can be ordered directly from Sensory research, 2424 Morris Avenue, Union, New Jersey 07083.

4 Sometimes the added intensity of stimulation provided by a vibrator is sufficient to trigger the orgasmic response.

5 Every first orgasm reported in the group is explored at length.

6 By "reliably orgasmic" I mean that a woman reaches orgasm most of the time she masturbates and has a good understanding of her process of sexual arousal and release.