Fundamental principles of sexual health for group psychotherapists and their groups

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ABSTRACT

Sexual health research and knowledge is an untapped resource for group therapists to improve treatment outcomes. After a brief review of current group literature as well as sexual health research, the author proposes three fundamental functions for leaders of sexual health based group work, functions which support the exploration of sexual pleasure, arousal, and desire while mitigating therapist and group member defenses and fears associated with honest and vulnerable disclosure of sexual history, behavior, and feelings. Sexual health principles are illustrated with clinical examples.

Key words: *group therapy—sexual health—group leadership—group process—sexuality--eroticism*

This paper recommends the application of principles of sexual health to group psychotherapy, principles that have been developed primarily in the fields of sexology,

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sex therapy, and public health. Group psychotherapists regardless of theoretical orientation can usefully bring these principles to their work by incorporating three functions of leadership necessary for groups to promote sexual health in their members: developing the group as a container for sexual health; taking a leadership role in inviting and pacing sexual health based interactions; and understanding and acknowledging a variety of leader behaviors and interventions that support or impede the group members' exploration of sexual health. These group leader functions must be informed by knowledge of sexual health principles beyond the typical understandings of sexuality available in most psychotherapeutic training. Human sexuality within group psychotherapy is "often [an] unspoken and ignored issue" (Courville and Keeper, 1984, p. 35).

Morris Nitsun's (2008) groundbreaking book, The Group as an object of desire: Exploring sexuality in group therapy, devotes a chapter to the only comprehensive review of the literature on group therapy and sexuality the author has found. Nitsun postulates that the "peculiar, avoidant, ambiguous silence" on sexuality and group therapy stems from either evasion of sex as a subject in groups due to unconscious collusion with dominant moral standards or "an as yet unspecified problem regarding the nature of group psychotherapy" (Nitsun, 2006, p. 6). This paper proposes that Nitsun's "unspecified problem" in group work has its origins in the absence of sexual health approaches to group work.

The Literature on Sexuality in Group Work

The literature on sexual issues and sexuality in groups seems to fall into four general categories, none of which necessarily utilize the principles of sexual health. The World Health Organization defines sexual health as "the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love." (2002) For the purposes of this paper sexual health is an interactive relationship between individual, group and leader sexual development, physiology, sexual functioning, emotions, sexual pleasure, erotic interests and capacity for love.

First are groups that address the sexual developmental negative consequences of sexual victimization, including female sexual abuse survivors (Frawley-O'Dea,1997; Tyson & Goodman, 1996; Longstreth et al., 1998), male sexual abuse survivors (Gartner,1997; Zamanian & Adams, 1997), and adult survivors of sexual abuse (Callahan et al., 2004; Heiman & Ettin, 2001).

A second category of groups attends to the negative health consequences of sexual behavior, focusing on group treatment as a method of improving health outcomes by reducing sexual behavior and interactions that are negative. Included here are groups addressing sexually transmitted infections (NIMH Multisite Prevention Trial group, 1998) and specific health consequences of sexual behavior and HIV infection (e.g., Sherman et al., 2004). Groups that directly address the negative health consequences for adults with paraphillic, illegal, offending, and out-of-control sexual behavior are also well represented in the group literature (Lehne et al., 2000; Ganzarain & Buchele, 1995; Pithers, 1994; Lothstein, 2001).

Third are groups that focus specifically on the sexual orientation of group members. This category is exemplified by the last three decades of gay and lesbian affirmative group therapy, often with homogeneous groups of gay and lesbian identified adolescents and adults. Members come to terms with their same-sex attractions, sexual desires, and sexual orientation identity development, and they integrate marginalized sexual status within family, work, religion, and society (Gonsiorek, 1993). These groups do not so much address intrapsychic difficulties as obstacles a minority group faces interacting with the dominant culture (Englehardt, 2004).

The inverse of this is found in sexual orientation conversion group therapy. Unlike gay and lesbian affirmative group therapy, sexual reorientation treatment utilizes group process to reinforce self hatred and assert heterosexual conformity as necessary to maintain attachment to a larger religious or cultural group (Haldeman, 2002).

The fourth category is groups that include sexuality, desire, and eroticism between group members and toward the leader as part of the process available for analysis. This category is the most common focus of the limited literature on sexuality and group therapy. In these groups, the clinician's theoretical orientation typically defines his or her understanding of the group sexual issues. For example, if the leader's clinical orientation is psychoanalytic, the sexual themes and dialogue of the group will usually be understood and analyzed in a way that is congruent with that particular theory. Principles of sexual health from outside the leader's theoretical orientation are rarely considered.

Sexual Health Based Group Work

This paper proposes a fifth category, in which principles of sexual health are incorporated by group leaders (including those in all of the previous four categories) in their groups. Sexual health group work integrates sexual health concepts into group work, adding sexual health research and data to the body of group literature, and exposing sexual myths, misinformation, bias and ignorance with objectivity.

Historical Review of Sexual Health

Sexual health principles, and group leadership functions informed by them, derive from an expansion, beginning in the 1970's, of the traditional definition of sexual health from focus on "venereology and the absence of sexually transmitted diseases" (Coleman, 2007, p. 7) to a much broader concept. For example, in 1975, the World Health Organization declared: "Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (WHO, 1975). More recently, many regional, national, and international organizations have revised definitions of sexual health (Pan American Health Organization, 2000; World Association for Sexual Health, 1999; World Health Organization, 2002, Office of the Surgeon General, 2001). Concepts of sexual health expanded to include sexual rights, definitions of sex and sexuality, and to integrate contemporary constructs of sexuality and sexual health. For example, 27 years after its initial statement, WHO clarified its evolving construct: "Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual

right of all persons must be respected, protected, and fulfilled" (WHO, 2002). The World Health Organization organized sexual health into three basic elements:

a. Control and enjoyment of sexual reproductive behavior;
b. Freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationships;
c. Freedom from disease that interferes with sexual and reproductive functioning. (Coleman, 2007, p. 7)

The Surgeon General's Report on Sexual Health

Two examples from the U.S. Surgeon General's office exemplify the value of collaboration in developing sexual health principles as well as respecting varying perspectives within groups. In 2001, U.S. Surgeon General David Satcher released "The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior," which was developed through a collaborative process "which sought the broadest possible input and [brought] together a wide range of experience, expertise, and perspective" (p. ii). Satcher combined the previously established WHO sexual health definitions with the "responsibilities that individuals and communities have in protecting sexual health" (p. ii). Thus the Call to Action is the foundation for envisioning and promoting sexual health within communities.

Satcher followed his national Call to Action with the Interim Report of the "National Consensus Process on Sexual Health and Responsible Sexual Behavior" (NCP, 2006). The NCP convened over 50 major U.S. constituency organizations to participate

in a consensus process on sexual health, with the goal of "broaden[ing] the common ground on issues of sexual health" (NCP, 2006 Letter from David Satcher). As in group process, the NCP revealed areas of agreement and disagreement. The NCP could not reach consensus on sexual abstinence, responsible sexual behavior, and sexual orientation. Nor could it define the term "sex" or reconcile its different definitions of sex within a broad range of different communities. It could not agree on the nature of sexual self-harm resulting from sexual activity, the specific age up to which sexual abstinence should be advocated, or sexual exploration within the context of sexual abstinence. It concluded that the term "sexual orientation" lacks basic usefulness in public dialogue, reflects bias, and is of questionable use for any kind of scientific inquiry.

The Interim Report of the NCP normalizes the wide range of sexual health conceptualizations that often result from highly charged judgments and biases. Therapists may be surprised by the wide array of controversy and contention around basic matters of sexual health, even among experts. When group leaders are familiar with the attitudes and feelings surrounding sexual controversies, they can welcome their groups to process divergent sexual beliefs.

The Three Functions of Sexual Health Group Leaders

This article proposes three significant group leader functions for sexual health based groups. First, group leaders are responsible for developing an adequate container for group sexual health. Second, group leaders should not rely on sexual minorities and those with marginalized sexual behavior to direct group attention towards sexuality.

Lastly, group leaders should understand and acknowledge how their interventions support or impede the exploration of sexual health.

Establishing the Group as a Container for Sexual Health

According to the American Association of Sexuality Educators, Counselors and Therapists (AASECT), the group leader is directly responsible for providing and maintaining group sexual health. "The practitioner creates a climate of comfort and permission for clients to discuss sexual concerns, often introducing the topic of sexuality, thereby validating sexuality as a legitimate health issue" (AASECT, web site, http://www.aasect.org/default.asp, retrieved August 23, 2008). This climate is fostered by a group leader committed to "stimulate respectful, thoughtful, and mature discussion" (Office of the Surgeon General, 2001, p. 2). Sexual health group work begins by balancing "diversity of opinion with the best available scientific evidence and best practice models" (Office of the Surgeon General, 2001, p.2).

The sexual health group leader must welcome divisions and contentions regarding sexual health. Just as Satcher welcomed agreement and painful fissures in our national sexual health conversation, so must group therapists create an adequate container for sexual health conflict. Experienced group therapists may have significant skills in facilitating a holding environment for diverse perceptions and feelings, yet feel anxious or embarrassed when facing contentious sexual diversity in their groups.

Creating the group as a container for sexual health begins in the initial planning.

"The more clearly [group leaders] can state [their] expectations, the better [they] will be able to plan and the more meaningful the experience will be for participants" (Corey & Corey, 2002, p. 98). Sexual health in agencies and treatment centers begins with the group proposal. For the private practitioner, it begins with initial planning. Group leaders should formulate questions for potential group members to address important sexual health concerns. How will the goals of this group enhance the sexual health of its members? What aspects of sexual health will most likely be a concern for this group? Group leaders should include a clear plan for addressing sexuality in the most formative stages of group development. If sexual health is not included in the formulation of the group, the leader(s) may fall back on conventional social norms of shame and avoidance of sexual discussion. This is the first sexual health barrier in the life of a group. A fundamental aspect of sexual health in group therapy is the leader taking responsibility for establishing, early and often, that group is a space for envisioning sexual health. Otherwise, this omission "will show up later in a variety of group leader problems and stressors that contribute to confusion and floundering among participants" (Corey & Corey, 2002, p. 98). The group proposal establishes the leader as the voice of sexual health in groups.

> *Lourdes and Henry are interns at a social service agency for lesbian, gay, bisexual, and transgender (LGBT) clients. Henry, a gay man who was recently married to his partner of eight years, and Lourdes, a heterosexual married mother of three, are trainees from a local graduate school counseling program. They will*

co-lead a newly forming "married men's coming out group" and need to write a group proposal similar to the model they were taught in their group therapy course. Henry learned in his human sexuality class that "adolescents, the economically disenfranchised, ethnic, sexual, and other minorities have the highest rates of sexual health problems" (Coleman, 2007, p. 7). He suggests that one of the purposes of the group should be to improve the sexual health of the members. A lively discussion ensues between the co-leaders about how sexual health related discussions will present in this group.

Lourdes and Henry are accepting the responsibility of envisioning the sexual health of their new group. Contemplating the sexual health of the members prompts group leaders to begin a productive sexual health discussion. Leaders, new or seasoned, who lack a theoretical foundation in sexual health may rely on their own sexual life to consider sexual matters. With a co-leader, this may lead to an emphasis on personal disclosure as a substitute for a sexual health based formulation. The premature movement to personal disclosure is a common strategy for resolving gaps surrounding sexual knowledge and training. At the other end of the spectrum are non-verbal "no-talk" messages that move the future leaders away from the subject of sex. Sexual health principles provide leaders with a structure with which to contemplate sexual themes without resorting to defenses.

Taking Leadership and Avoiding Group Reliance on Sexual Minorities

Sexual minorities in groups often do the initial sexual work of a group. In the last

twenty years, the emergence of openly gay and lesbian group members as well as well-trained lesbian, gay, and bisexual group therapists has tilled the soil for groups to address sexual themes. A group, for example, may use heterosexual orientation and non-heterosexual orientation as the primitive content for addressing group sexuality. In a homogeneous gay or lesbian group, this dynamic is revealed in content focused on "outness": Who is more out than whom? Degree of outness is often associated with capacity to bring sexuality and sexual content into the group.

Thus, sexually marginalized or gay/lesbian-identified members will often take the lead in sexual discourse, moving the group to "have to talk about it" by declaring who they are. Same-sex orientation may assume the burden of responsibility to bring sexuality into the group. A sexual health group leader must be conscious of this pattern and, if necessary, intervene.

Nitsun cautions group leaders about the pitfalls of "facile assumptions about sexual difference and acceptance, as if the fears and prejudices of the past have simply been wiped out" (Nitsun, 2006, p. 47). He places the responsibility on group leaders and "the extent to which they represent an open and enquiring approach to all sexuality, which includes recognition of their sexual preferences, anxieties, and blind spots" (Nitsun, 2006, 47-48). Members should be helped to rely on the leader for guidance in sexual health in the group relations. The leader can meet unmet dependency needs from childhood and adolescence, when the struggle to form a beginning sense of sexual self may have occurred in isolation, shame, pain, or with incompetent caregivers. Patient

invitations for pacing sexual content creates a message from the leader of "I know where we are going. Let me help you make it more conscious."

> *Theresa specializes in work with women survivors of sexual abuse and assault. Her current, ongoing group is comprised of seven women ranging from 63 to 26 years old. Theresa noticed a pattern in the group process. Each time a new member enters the group, the two lesbian members bring up sex. Candace, a vibrant 37-year-old partnered lesbian, proudly discusses how much the group has improved her sex life with her partner. Libby, a 56-year-old divorcee who has for the first time entered into a love relationship with another woman, joins Candace in disclosure of her new sex toy, which is a source of much masturbatory pleasure in healing her relationship with her body, following a brutal sexual assault 12 years ago.*

Theresa may be replicating a common leadership norm, reliance on homosexual group members for entrée into group sexual discussions. Sexual health based group leaders accept responsibility for initial group sexual discussions. Group leaders without adequate sexual health training and supervision will unconsciously appoint gay and lesbian group members as gate-keepers for sexual topics. The members may feel unconsciously obligated to assume the role of de-facto representative or expert on sexual themes in the group. When sexual minorities, whose lives have often made them more sexually conscious, take responsibility for group sexual themes, the leader is unable to attend to all the members' sexual lives. This group leader abdication may block awareness of diverse

opinions and differing viewpoints of other group members. Contentious, controversial, and divergent attitudes and beliefs about homosexuality, masturbation, and unconventional erotic interests may remain unspoken.

Developing a Knowledge Base of Leader Interventions That Support or Impede Sexual Health

This brings us to the final fundamental function of group leaders in sexual health based groups. There is a wide variety of leader behaviors and interventions that support or impede exploring sexual health in groups, including the use of appropriate language, the suspension of judgment, the management of affect stimulated by discussion of sexuality, awareness of the leader's own erotic desires, a capacity for appropriate pacing of movement towards and away from sexual and erotic content, and the integration of sexual health information with the leader's preferred psychological theory and style of leadership.

The language of sexual health

Just as with the NCP, sexual health based group work begins with the language of the leader. Language is the first barrier to sexual health or the first invitation that welcomes sexual health work to the group. The mental health profession, and more specifically group psychotherapy, is not a cutting-edge field, sexologically speaking. I tell my students who want to learn the language of sexual health that they must leave the confines of psychology, psychiatry, and psychotherapy and enter the foreign territory of

sexologists, sex researchers, sex educators, sexual public policy makers, and sex therapists. Mental health professionals are not likely to find group psychotherapy expertise within these disciplines.

Given the absence of sexual health information in group therapy clinical literature, I propose that sexual health based group leadership requires facilitators to creatively link sexual science, sexual health, and accurate sexual language with group psychotherapy. Just as groups begin to come to life when we bridge and connect new members who have yet to come to know each other, sexual health based group leaders will experience a spark of creativity, of inspiration, of passionate courage when they risk being an outsider and enter the world of sexology and sex therapy--not to become a specialist in sex, but to know their strengths and blind spots regarding sexual health. Thus, for example, sex conferences and workshops can help group therapists to discover unseen sex negative attitudes and sex phobic feelings. Listening to sex researchers describe their studies is an opportunity to hear the language of sexual health separated from sex negative psychological theory, which is often replete with value judgments, prejudices, and unfounded assumptions. Their language is an important tool in developing a sex positive, sexual health based group therapy language.

Sexual health trainings challenge another sexual health barrier in leading groups. Group therapists tend to conclude that sexual matters in group are satisfactorily discussed by metaphor, pronouns, poetic imagery, and vague speech. When group leaders settle for generalizations as sufficient dialogue for discussing a sexual worry,

problem, or disorder, a vital link to the language of sexual health is lost. I have found that the affect and insight regarding sexual concerns and the potential for meaningful connection and contact can only arise out of specific and detailed sexual language:

> *Tracy, a 34-year-old single heterosexual female nurse is in group therapy for treatment of depression. Recently divorced, she has begun to consider dating. She is using online social networking sites and her vibrant off-line social network for meeting men. One of her most worrisome depressive symptoms is "no interest in sex." When she exclaimed to the group, "I'm frigid!," there was no response, as if the members were saying, "What do we do now?"*

A sexual health moment for the leader is to listen quietly to the group language in response to this disclosure. In a psychotherapy group, the content may move quickly to affect and feelings. A sexual health based group intervention encourages the discussion to move from the abstract to the individual. Specific discussion about sexual functioning, current sexual desire, and the client's experience with her sexual response are all relevant group content in response to the sex-negative term "frigid." In this case, a woman who does not currently have a partner may be learning of her inorgasmic symptom through attempts to masturbate. The leader might listen for euphemisms for masturbation, orgasm, sexual excitement, and genitals. A sexual health group leader intervention is to ask for clarity. The leader may look to the group for what they think Tracy is telling the group.

> *Lucinda, a 48-year-old Latina lesbian, asks Tracy if she ever "does it herself?"*

The leader asks Lucinda what she wants to know. Established group norms give a foundation for Lucinda to know what the leader is asking. Lucinda blushes a bit and says, "Oh, this is so hard, we could never talk about such things in my family." The leader again asks, "What things?" Lucinda says, "You know, don't make me say it!" The leader looks to the group and says, "What does the group think Lucinda is having a hard time saying?" Gabriella, 54-year-old longtime group member, says, "I remember the first time I said the word masturbate in here. It was such a strange feeling in my mouth to even say the word." The leader returns to Lucinda and inquires if Gabriella was correct about the word. Lucinda says yes, and the leader has Gabriella use the word. She quickly says "masturbation" and looks simultaneously embarrassed and relieved. The leader looks around the room, takes a quick temperature of the group and waits. The patience and stillness of the leader communicates a sense of ease and relaxation in response to the group focus on a sexual health problem.

A wonderful web site for learning the difference between vague sex-negative terms and sex-positive language is the Magnus Hirshfeld Archive for Sexology. The Archive for Sexology has a mission to "promote, protect, and preserve sexual health through original research and by collecting, analyzing, and disseminating scientific information from other sources" (http://www2.hu-berlin.de/sexology/index.htm, retrieved August 23, 2008). The Archive includes a Dictionary of Inappropriate Terms, which lists inappropriate scientific and professional sexological terms in an alphabetized glossary.

> Sexological research and training are often hampered by traditional terms that contain hidden value judgments or are even openly ideological. Originally, they were part of semantic strategies by which various religious, legal, medical, and pedagogic 'experts' tried to impose their professional interests or moral convictions upon the general public. In addition, there are many imprecise and misleading terms still current in our field, so that it is often extremely difficult to describe sexual matters in an objective way. (retrieved August 23, 2008)

The site also has a "Critical Dictionary of Sexology" that is a constant work in progress with up-to-date sexual health words and definitions. This valuable resource assists group psychotherapists in distinguishing between sex negative, biased, and value laden group norms that reinforce existing societal and cultural sex negative ideas and perceptions and a sexual health based group container for sex positive sexual health based relationships.

I facilitate a large group empathy-building exercise when conducting sexual health trainings. The Magnus Hirshfeld inappropriate terms are individually sealed in envelopes. The corresponding definitions are in separate envelopes. The task of the large group is to open their envelope, read the term or definition, and then match them by roaming about the room. Participants wander about amongst their colleagues shouting, "Does anyone have perversion?" "I need sodomy." "Does anyone know what inversion is?" The laughter and emotions lead to personal insight and critical thinking about sexual language and groups.

Suspending judgment

The leader's ability to suspend judgment is a necessary skill for sexual health based group therapy. Group members often focus on the leader after the disclosure of highly personally conflicted sexual experience. The leader may be expected to rescue them from facing judgments of group members, and they may be anxious about resorting to their own judgments. The group wants the leader to assume the role of arbiter of sexual values for the group. This regressive group process reflects an underdeveloped sexual self and sexual health based self-concept for group members and the group as a whole. The leader needs to resist the seduction of moving into such a powerful position. The sexual health intervention is to return the group to focusing on the feelings, content, and process in the room. Again, in areas other than sex, this is a cornerstone of a skilled group therapist, yet with sexual content, there may be little experience and confidence in even seasoned group therapists.

> *Pham is a 25-year-old single second generation Vietnamese-American gay male in an anxiety and phobia treatment group. He had his most acute and severe panic attack four days ago while at a 53-year-old anonymous sex partner's home. He had met the man online for the first time two hours before the panic attack. He is talking about the panic attack with the group and explains how helpful Jim was in getting him through the attack. Zachary, a 31-year-old married father of two young boys, asks Pham who Jim is. Pham describes how he met Jim online and was looking forward to having sex with him. Zachary becomes noticeably quiet and still. It is unclear if his response is connected to Pham's disclosure of his*

recreational sex situation or his panic attack. The leader waits. Pham goes on with his story, focusing on how well he utilized his skills for managing his panic and how much worse the attack could have been without his group work in managing it. Zachary interrupts and asks him if he thought the panic attack was from Pham placing himself in a "dangerous situation." The leader sees the focus moving to the sexual situation as Pham begins to sound defensive. "I didn't come here to focus on my sex life. It was not dangerous. What makes you say that"? The leader waits. Zachary, now clearly agitated, says, "Oh, come on, Pham, you go to a complete stranger's house to have sex. Don't you think that is pretty poor judgment?" The leader waits. Eventually Pham and Zachary become argumentative. No other group members intervene. They become spectators.

The leader brings this experience to supervision and explores this "watching" position. The leader realizes that the Zachary-Pham interaction echoed the leader's inner dialogue. Identifying his primarily judgmental thoughts about risk, danger, and lurid curiosity about anonymous recreational sex leads to clarifying the leader's feelings. He felt anger towards Pham for bringing his sexual life into a group treating anxiety and panic. He shared Zachary's critical evaluation of Pham's online sexual behavior. Anxiety, dread, and embarrassment flooded his body as he watched Zachary enact the judgments in his own mind. The leader's silence let Zachary speak the critical evaluation so he did not need to suspend his own judgments. This inability to suspend judgment limited the leader's ability to attend to the group process, which resulted in a focus on the

sexual behavior at the expense of the client's situation and the marginalization of the panic management treatment.

This example illustrates several leader dynamics that impede the exploration of sexual health. The emergence of details of group members' sexual lives creates in the leader the need to rectify assumptions about members' "sexual self" with facts now introduced into the group. In this example, Pham revealed a discrepancy between the leader's knowledge and the leader's assumptions about Pham's sexual life. The group leader often makes assumptions about each group member that are somewhat idealized. This sexual idealization may arise from the omission of basic sexual health history during group assessment and lack of training and experience with sexuality and psychotherapy. When the leader does not adequately prepare new members to discuss erotic feelings as part of group work, the leader will often feel stuck or at sea, as a result of the divergence between the idealization and the client's disclosure. This lack of preparation will result in members not knowing how the leader addresses sexuality.

Sexual health affect management

A group that is insufficiently prepared for sexual themes and content can be flooded with unmanageable feelings. Unfortunately, this flooding will often be erroneously associated with the sexual content. Synaptic intensity may lead to an error in logic that sounds like "sex is too scary to talk about." When a group has been properly prepared for sexual content and the leader maintains a focus on both sexual health and clinical symptom management, group members will be more self-reflective. The group may move more readily to engage at the level of "Hmmmm, I wonder what this feeling is

about," without prematurely concluding that the feelings must be exclusively linked with sexual content in the group.

The group leader's own erotic desires

Leaders must prepare to experience their own sexual stirrings as a component of sexual health based group work. First, group therapists must identify and understand their unresolved feelings of mistrust and wariness of their own sexual urges and thoughts. This is an area where training from sex therapists is helpful. Sex therapists have effectively normalized sexual countertransference as an essential aspect of working with sexual themes. Once they surmount their anxieties and judgments regarding sexual countertransference, skilled therapists can utilize their existing psychological theory for navigating this terrain. Unfortunately, when leaders do not acknowledge these desires , they may take premature action focused on solutions. This poorly timed movement to action may manage leader anxiety rather than propel group process. .

Jack Morin in The Erotic Mind (1995) proposes that attraction and obstacles together generate erotic feelings; attraction alone is not sufficient. Eroticism requires barriers, obstacles, and obstructions along the path of attraction. Without these barriers, the attraction remains just that, an attraction without the concomitant charge of electrical erotic energy. The group leader's inhibition about sexual stirrings is a sufficient obstruction, when combined with attraction, to generate erotic arousal. Sexual health based group therapy requires leaders to have a basic understanding of erotic feelings, including minimal consciousness of their own erotic map: "What are the obstacles that are erotic for me?" Examining the erotic themes of thousands of men and women sharing

their peak erotic experiences, through an online research program, Morin found four common themes that interact to focus and generate erotic feelings and sexual behavior. Morin's "Four Cornerstones of Eroticism" are founded on the notion that the "universal challenges of early life provide the building blocks for adult arousal" (Morin, 1995, p. 74). These "existential sources of arousal enhancing obstacles" are: longing and anticipation, violating prohibitions, searching for power, and overcoming ambivalence (Morin, 1995, pp. 74-75). Perhaps, in our clinical example, the leader was erotically charged listening to a group member describe a forbidden or taboo sexual behavior and was thus distracted from attending to the group process by his own sudden erotic energy.

Pacing sexual and erotic group work

Group sexual health is enhanced when leaders avoid premature movement either to suppress or to move towards sexual content. Groups unprepared for sexual content may collude with the leader in suppression of erotic content. Groups may attempt to reward the leader, through silence, for not taking the group into sexual themes and content. Benjamin Kothow (1957) wrote about group tendency to inhibit sexual content as a reflection of societal limitations on sexual talk. Alternatively, leaders may choose to blithely move directly into the sexual content, "ready or not." This defensive movement denies the leader's as well as the group's affect by unempathically moving quickly into sexual content ungrounded in discussion of group process.

> *I was facilitating a demonstration group at an American Association of Group Psychotherapy workshop. Four men and four women of various ages, ethnicities, and sexual orientations, had volunteered to discuss their reactions in response to*

my didactic material on sexuality in group therapy. Sitting quietly, I let the group begin. Within ten minutes, a delightfully eager participant cued the group that he was about to disclose significant content about his current sexual life with his male partner. The sexual health moment for me was to quickly assess the "readiness of the group" for his invitation to jump into the deep waters right away. I know this defense. I chose to facilitate the moment by remembering the words of Jack Morin:

> *"To uncover what has been long hidden, be patient and gentle; allow the erotic mind to reveal itself at its own pace as it tests the waters. Practice offering yourself invitations to see more, to comprehend more, to accept more, to enjoy more. Each invitation carries with it the freedom to decline or to wait. The goal of erotic self-understanding is furthered by a willingness to ease up in the face of your own reluctance. (Morin, 1995 p. 12)*

A leader risks empathic failure by letting the group move too quickly into sexual content, especially in a demonstration group with fifty colleagues.

I chose to engage with the enthusiastic learner. I asked him to reflect a moment—without yet disclosing his story--on the meaning of his disclosure. What were his hopes and desire with the group in sharing his story? What longing was held in this enthusiasm? He moved to a deepening affect. His eyes welled with moisture. He identified himself as a gay therapist and began to discuss his eagerness for this workshop: how much he thought about coming to the workshop and the anxieties he felt, his isolation and hunger for training and support in the difficult work of

facilitating groups of gay men who are themselves so hungry. After he shared his longing, I again invited him to reflect on the content of what he wanted to discuss. He looked around the group and realized he did not know the members and wanted to first connect on a different dimension. He decided it was "too soon" and wanted to wait a bit before jumping in..

The demonstration group example highlights another barrier to sexual health in groups, which is the leader's misattunement to group pacing. Members often fear disclosing erotic feelings toward each other. If the leader moves too quickly to sexual content connected with excited feelings, the group may become anxiously attuned to the sexual content and move away from an important pacing function. The leader may need to assess whether to move towards erotic content by first addressing the group process and stage of development. Group process focus can diminish the erotic charge to allow for self-regulation and affective attunement among group members before moving directly to the content of the sexual attraction. Meaningful sexual health norms will unfold only when group members process their sexual pleasure, arousal, joy, satisfaction, and exhilaration at a gentle pace.

When I train professionals in sexuality and group work, I often start by saying: "We are about to have an unusual experience for adults and mental health professionals. We are going to spend time together discussing sexuality in a safe, respectful, and informed manner." I remind them how rare this is for group therapists. The leader who maintains the consciousness of this process creates empathy in the group and confidence in his or her leadership.

Group theory

Leaders feel most at home in their theories. We rely upon theories to structure and understand the complexity of human behavior and--for the group therapist--our understanding of who we are in connection with others. Group therapy highly values group process, the here-and-now interactions among the group members, as a vital part of the healing potential of group. But theory can also be a barrier if it lacks guidelines for group leaders to address concepts of sexual health and negativity.

An important and often unconscious motivation for patients joining a group is to find a safe place to discuss their sexual life and love relationships. Depending on the theory, some group leaders may overly value the gold standard of sexual themes expressed within the group, including the leader. This may marginalize discussion of erotic material not centered within group relationships. Other group therapists may rely on theories that emphasize material external to the here-and-now group process. This is more prevalent in groups focused on prevention, sexual behavior, or specific sexual functioning.

Much sex negativity is embedded in psychological theories, influenced by pervasive sex negativity within society in general. Group theory is a barrier to healthy sexuality if iti s not aligned with contemporary definitions of sexual health. Sexual health group work transcends the pull towards a singular psychologically based sexual theory as clinically adequate to address the wide variety of sexual worries, problems, and disorders clients bring to group. Any clinical treatment approach can be creatively adapted to sexual health principles and be useful in a range of social, cultural, and clinical group

settings. Definitions of sexual health bring a social context of sexuality to the group, which supports the group in acting as a container for individual members to envision their own sexual health.

Leadership style

Speaking as a trainer, modeling a sexual health leadership style is a primary teaching instrument. I believe group therapists best learn sexual health approaches to group work when the trainer or demonstration group leader is a seasoned group facilitator. Trainer competence helps participants to absorb sexual health modeling. Sexual health group work modeled by inexperienced professionals may result in defenses that devalue the information as irrelevant to group facilitation.

Group leaders will deepen their belief in their capabilities to lead sexual health based group work only if they are willing to succeed and fail. Just as groups leaders can interfere with group sexual health development by moving a group prematurely into sexual terrain, they can diminish their self confidence by moving too quickly into sexual health based group work without a support system for processing disappointments, struggles, and success. A mentoring system of supervision and training in sexual health is valuable for long-term growth.

As the group leader presents a more consistent sexual health leadership style, groups often move to a self-efficacious position. A group norm of "we can do this" when addressing sexual concerns becomes a potent source of increased client retention and better treatment outcomes. A consistent leadership style for processing sexual content

generates an enormous capacity for processing shame, anxiety, guilt, fear, and self-loathing associated with unprocessed sexual conflicts.

> *Virgil, a 34-year-old Latino immigrant from Uruguay, is a single gay-identified male who has recently been diagnosed with HIV. He is in a group for gay men in early adjustment to HIV infection. He has disclosed his HIV infection to the group, his medical care team, and two friends, but not to his family, most of whom live in South America. Virgil disclosed to the group that he had been online at a social networking site and was cruised by another man who was interested in meeting him over coffee. This was his first invitation for a date since he knew of his HIV infection. Virgil told the group about his anxiety surrounding disclosure of his infection. The leader is very experienced with this dilemma and invites Virgil to articulate his conflict. The leader is focused on Virgil finding the solution from the perspective of readiness for action and his sense of obligation. What does Virgil want from the group? Some members focus on their memories of the first time they were in this situation. Others suggest specific strategies for interacting on the date. Group members and the leader could be thought of as representing various "sexual health standards" as well as "taboos" to be avoided or challenged. The leader could ask Virgil: "To what extent does the group sound like the conversation in your mind?" A quiet member, who appears distracted, could be seen as a symbol of the fantasies and thoughts Virgil has about his family back home, as well as the various people in his life with whom he has withheld his infection.*

When the leader uses sexual health based maps to guide the group process and keeps an eye on anxiety about discussing sex, group therapy can be an island of sexual health in a sea of sex negativity, silence, and fear.

Summary

Group therapy is a unique and important resource for developing sexual and erotic health, when leaders create an environment that addresses sexuality in all aspects of group development, from formulation of the group proposal, purpose, and goals; to the entire recruitment, screening, assessment, and selection process; through orienting new clients, developing treatment goals, defining group guidelines, and becoming familiar with sexual health principles in both group content and process.

When a group leader has a system in which to organize and understand the multitude of sexual health worries, problems, and disorders of group members, he or she can assist the group in clarifying self-discrepant sexual behavior, feelings, thoughts, fantasies, desires, and choices. Group sexual health will emerge when the group is a container in which to explore each member's disappointments and failings to meet sexual health standards. Sexual health group work clarifies the multiple sources of these violations, which may stem from standards established by a spouse, religion, culture, belief system, or the group itself. Sexual health based group work will provide a place for individuals, subgroups, and the entire group to explore and understand emotions, thoughts, and conflicts elicited by discrepancies in sexual health standards. Just as the World Health Organization and other sexual health leaders have been expanding limited definitions of sexual health for over thirty years, so group psychotherapists should

envision the sexual health of their groups beyond the current cultural and societal confines group members bring with them at the start of each group session.

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