

## A SEX ADDICT SPEAKS

Sharon R. Edwards, MA  
Editor

In these times of conservative politics, the Moral Majority, and AIDS, it is not surprising that the term "sexual addiction" has emerged. After free love, open marriage, legalized abortion, and the feminist movement of the 60s, the sexual problems in the early 70s were focused more upon not having enough sex—inability to have orgasm or maintain an erection or lack of desire—rather than having too much. During that era, we rarely heard about professionals addressing the issue of an inability to control one's sexual behavior with respect to frequency and/or number of partners. In fact, as a teenager growing up at that time, the predominant feeling was that you were abnormal if you did not have sex whenever, wherever, and with whomever possible.

But these days, in both the professional community and the popular media, we are hearing more and more about the condition of sexual addiction. The problem itself is not a new one. In the past, it has been called nymphomania or Don Juanism. And we certainly have always had sex offenders—child abusers, exhibitionists, incest perpetrators. But it is only in the past few years that uncontrolled sexuality has been identified as an addictive process in which anxiety, loneliness, and pain are temporarily relieved through a sexual high not so unlike that obtained from drugs or alcohol.

The term "sexual addition" has created quite a stir in both the sexology field and the popular media. The term first appeared in 1978 in the *Journal of Addictions*, a journal unlikely to be seen by many professionals in the field of sexology. Before any professional recognition of this condition, former members of Alcoholics Anonymous (AA) founded groups based upon the 12-step model of AA for treating sexual addiction. A few years later, this condition did start to receive professional attention. In the early 80s, for example, Mark Schwartz of Tulane University, formerly with Masters and Johnson, recognized that men who were arrested for incest showed signs of addictive behavior, not to drugs or alcohol but rather to sex. Schwartz hypothesized that for the sex addict, sexual fantasies and urges served to reduce anxiety temporarily by providing an illusion of power or intimacy that compensated for feelings of worthlessness.

Others, however, are not convinced that the condition

even exists. Sexologist Richard K. Sharon, for example, believes that until we can define what "normal" frequency of sexual behavior is, we cannot label people as sex addicts. New York psychologist and gay activist R. William Wedin has traced the origins of the concept of sexual addiction to the Bible Belt in the late 70s. Wedin believes that this condition emerged as a reaction to the sexual revolution of the late 60s, particularly with respect to the consciousness raising of heterosexual women, and that gay men have recently been targeted as sex addicts as a result of the growing homophobia surrounding the appearance of AIDS. Helen Singer Kaplan, a well-known New York psychiatrist specializing in sexual problems, does not believe that sexual addiction should be a distinct diagnostic category due to its rare occurrence and lack of distinction from any other compulsive disorders, such as gambling. In fact Kaplan goes so far as to say that sexual addiction is a media term that has no scientific validity.

Who is in a position to establish how often and with whom the healthy adult should have sex? Psychiatrists or psychologists? Society? Individuals? Eli Coleman, one of the leaders in this field, believes that sexual behavior is on a continuum and that the distinction between healthy and addictive or abusive sexuality is determined by whether the behavior is self-enhancing or self-limiting. Patrick Carnes, one of the pioneers in sexual addiction, has said that people whose sexual behavior has seriously interfered with their lives in terms of health, occupation, or family have identified *themselves* as sex addicts.

In order to understand better the validity of this condition from the perspective of someone who feels afflicted by it, I conducted the following interview with a woman who identifies herself as a sex addict. Carol (fictitious name) is a lesbian in her mid-forties who has sought treatment for sexual addiction. She was raised in an upper-middle-class family in the Northeast, with a Jewish/WASP parental background and no permanent religious affiliation. She is a very bright and attractive woman who has had some college education and has always been active politically. Carol's story describes the kind of emotional pain experienced by a sex addict and provides insight into both the etiology and implications for treatment of this condition.

Q: When and why did you feel that your sexual behavior was a problem?

A: I knew all along that my sexuality was a problem—back as far as high school. I didn't realize that I was a sex addict until I stopped drinking and doing drugs. I was in Alcoholics Anonymous (AA) at the time. I realized that I had to stop having sex or I would start drinking again. I was using sex with men to avoid dealing with my sexual feelings about women. I decided to go to Sexual Compulsives Anonymous (SCA).

Q: How did you hear about SCA?

A: From the guys at AA. They talked about it. I knew about it for a year before I finally decided to go.

Q: Have you had any other addictions?

A: Yes, I've spent my whole life juggling my addictions to stay alive. I went to Overeaters Anonymous (OA) first for bulimia. I was also drinking at the time. I thought that I wasn't an alcoholic if I didn't drink alone because my mother, who was an alcoholic, always drank alone. Then I was sent to AA by OA. For years I substituted one addiction for another. I've been addicted to alcohol, drugs, sex, food, caffeine, cigarettes, shopping, and gambling.

Q: When did you first experience addictive behavior?

A: I started overeating, drinking, and smoking cigarettes when I was in high school. In high school I was aware that food had become a priority in my life.

Q: What was going on in your life at that time?

A: My mother's drinking had gotten worse. I couldn't deal

with my sexuality. I tried to repress it. I knew that you had to remain a virgin in high school. I also knew that women were expected to sleep with men. I was very uncomfortable around boys.

Q: It has been suggested by those working in the field of sexual addiction that many sex addicts were abused as children. Where you abused as a child?

A: I wasn't abused physically or sexually, but emotionally. I was raised in a very proper home, where everyone repressed their feelings. My family was very rigid. My father was racist and homophobic. He destroyed me. He took out all of his anger and lack of self esteem on me. He constantly threatened to send me to reform school.

Q: Why?

A: Because I disrupted this pristine family. I was an incorrigible child. After my sister was born, when I was 2½ years old, I tried to smash her with a lamp. I was used to being the only child among pampering adults. My sister and I fought constantly. When I was 11 years old, I stabbed her in the leg with a knife. Whenever she would upset me I'd threaten to do the other leg.

Q: What was your relationship with your mother like?

A: I liked her. She had so much that was good about her. She was a totally self-sufficient woman, but my father ripped her to pieces like he did to me. He ridiculed her constantly. Neither of them had any self esteem. I don't think she would have stayed with him if she had sobered up.

Q: Did your parents have any problems with their sexual behavior?

A: Not that I was aware of.

Q: How was the issue of sex treated in your family?

A: It wasn't. As far as I can remember, my parents didn't express it in front of me.

Q: When and with whom did you have your first sexual experience?

A: Graduation night in high school. I had sex in a cemetery with a friend of my girlfriend's. She said he would be good to break me in.

Q: Was it a good experience?

A: No. It hurt, and it didn't turn me on. I didn't have an orgasm. Then I started having sex whenever possible in order to have an orgasm.

Q: When and how did your sexual addiction first manifest itself?

A: After college, when I was about 24 years old and had moved to New York. I met a guy who knew how to get women off. After I had an orgasm, I wanted to have sex all the time. I felt totally free sexually. I would have sex constantly. I also got into bestiality. After this guy would have sex with me, his dog would lick my genitals. I used sex as an escape, to avoid dealing with life. My whole life revolved around having sex. The only time I had any self worth was when someone was having sex with me. I felt that sex was all I could offer in a relationship. I also felt powerful when I pleased someone sexually. When my psychiatrist asked me what my main goal was I told him it was to have as many orgasms as possible.

Q: Did you usually have several lovers or one?

A: I had sex with whoever I could. Many of my lovers were alcoholics. I often moved in with the guys I slept with. I was monogamous only when someone was paying the rent and taking care of me. I had to have sex every night. One night a friend brought over a bunch of guys and we did cocaine and I had sex with them for six hours straight. I hurt so much that I started crying. I was supposed to get paid, but I was paid in cocaine rather than money.

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Q: Did you become a prostitute to support your drug and alcohol habit?

A: No, this was the only way I could make enough money to support myself. I had no skills and I couldn't survive in New York on the amount of money from regular jobs. I started doing hotel calls and made a lot of money. Then I got into shopping and gambling. I spent my days in the department stores and my nights hooking. I was also spending a lot of money playing the stock market.

Q: How did you first become involved in prostitution?

A: I fell into it. I was at a supper club and a guy approached me and offered me \$100 to sleep with him. I didn't go with him at the time, but six months later I called him. Then I either worked as a prostitute or lived with someone.

Q: What happened after you sobered up in AA and decided to stop having sex?

A: I stayed celibate to avoid drinking for 2½ years. I knew that if I had sex I would not be able to stay sober. After I was sober and celibate for two years I thought I was cured of my sexual addiction. I started opening up to my feelings about women. At the age of 39, I "came out" and started sleeping with women. The first time I had sex with a woman I didn't have an orgasm and that made me angry. Then I did have an orgasm and again I couldn't stop having sex. I felt so comfortable with women. All I wanted to do was be in bed. I got into sadomasochism (S&M) and became addicted to that. Then when I got involved with the second woman, I didn't have sex because I was afraid I would get out of control. But we would go to women's porn movies and women's discos and read porn. This was all I would do. I couldn't take care of myself. I wasn't able to deal with my sexual addiction until I sobered up.

Q: What kind of experience did you have with SCA?

A: It was wonderful; it saved my life. Everyone in SCA has an individual recovery plan that they create themselves. They use the same 12-step method as AA. In SCA the people share their experiences, strength, and hope.

Q: How often did you go to meetings?

A: I went every night that I could at first—up to 4 or 5 times a week for several months. The program prevented me from getting involved in obsessive relationships. I will continue going to SCA in order to stay celibate for many more years. I don't feel that I've totally recovered yet.

Q: How do you feel about the label "sex addict"?

A: I think it's an accurate term. I still would like to have sex all the time. I'm an addict.

Q: What is your present condition in terms of your addictions?

A: I've been off drugs and alcohol for 5½ years, off cigarettes for 3½ years, off caffeine for 2 years, not bulimic for 2½ years, and celibate for 2½ years.

Q: What are your future goals?

A: I want to become self sufficient and financially independent. I don't feel that I can have a healthy relationship until I'm able to take care of myself. I'm also afraid of getting involved with someone who might become dependent on me. I'm just starting to put together my own life. I don't feel that I can even date at this point or buy sex toys or pornography. I think I would focus on it too much.

Q: Would you recommend SCA to others?

A: Yes, I agreed to do this interview so that others could hear about the program and be helped.

While this is only one example of a sex addict and each individual's problem is unique, Carol's problem of multiple addictions is often found in other sex addicts. For two different in-depth perspectives on sexual addiction see the following

articles by Patrick Carnes, an addictionologist, and Eli Coleman, a sexologist. Each offers a different theoretical basis and implications for treatment.

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## DO YOU KNOW THAT...

### AIDS/ARC: Update '86

On July 25 and 26, 1986, various AIDS service providers and support groups in San Francisco are holding a conference that will highlight recent advances in clinical management of AIDS patients as well as the latest research findings. A wide range of care providers will find this conference pertinent: nurses, social workers, mental health practitioners, health educators and others who work in acute and/or chronic settings. Topics will include medical and epidemiological information; medical implications; psychological issues; groups at risk; legal, social, political, and educational issues. For further information, contact: Renee Renouf Hall, AIDS/ARC: Update '86, Staff Development, Langley Porter Psychiatric Hospital, Box 32B, The Medical Center at UCSF, San Francisco, CA 94143.

### Free Breast Self-Examination Kit

The American Institute for Cancer Research is distributing free breast self-examination instruction and reminder kits. These kits may be obtained by sending a business-sized stamped, self-addressed envelope to: American Institute for Cancer Research, Dept. BSE, Washington, DC 20069.

### New Journal: Call for Papers

The Haworth Press, Inc., has announced the forthcoming new publication, the *Journal of Pastoral Psychotherapy: Innovations in Clinical Research, Contemporary Practice, and Theological Reflections*. The first issue is scheduled for spring 1987. Articles of particular interest are those that acknowledge the social context of behavior as well as those that reflect an empirical basis. Prospective authors should first request an Instructions for Authors brochure from: Harold T. Kriesel, PhD, Editor, *Journal of Pastoral Psychotherapy*, The University of Iowa Hospitals and Clinics, 2147 Steindler Building, Iowa City, IA 52242.

# WHERE THE ACTION IS

## Progress in Sexual Addiction: An Addiction Perspective

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Over the last fifteen years the new professional discipline of addictionology has emerged from the extensive foundations laid in both research and treatment of alcohol and drug addictions. Led by organizations like the American Academy of Addictionology and scholarly publications like the *Journal of Addictive Behaviors*, researchers have found that different addictive behaviors (e.g. compulsive eating, alcoholism, compulsive gambling, smoking) have much in common. It is not surprising that sex has only recently been added to the list, given the guilt and shame still attached to the subject. Nor should it surprise us that the professional controversy far exceeds that of other forms of addiction.

### Defining Sexual Addiction

The fact remains that a significant number of people have identified themselves as sexual addicts: people whose sexual behavior had become "unstoppable" despite serious consequences. These consequences include the physical (self-mutilation, sexual violence, disease, unwanted pregnancy), occupational (large financial losses, job losses, sexual abuse and harassment, withdrawal of professional licenses), and familial (loss of relationships, impaired family functioning, sexual abuse, sexual dysfunction). In addition to those problems, one of the most frequent mental health complaints of sexual addicts is suicidal ideation.

Another frequent complaint of "recovering" sex addicts is that the mental health community does not acknowledge their problem. They become enraged when sexologists dismiss sexual addiction as a problem of sexual misinformation, or excessive guilt due to cultural dissonance, or not a serious or widespread problem. I recently spoke at a Sexaholics Anonymous convention in which participants were rageful and moved to tears over statements made by professionals in a *New York Times* article. Stepping back from the intensity of their feelings, I had to reflect that compared to the amount of time taken to gain acceptance for the concept of alcoholism, the progress made in sexual addiction is remarkable.

My purpose here is to summarize this progress from an addictionologist's point of view and to specify further challenges which will require the close cooperation of specialists in addiction and professionals in human sexuality.

### Case Study

Consider the case of Larry, a 45-year-old manager of a computer programming department. Larry was arrested for exhibi-

tionism and sent to a court-mandated group for eight sessions. The group focused on the exposing behavior, but from Larry's point of view it was merely the tip of the iceberg. He had a 15-year collection of pornography, carefully cataloged and indexed. He saw prostitutes three to four times a month and masturbated daily—sometimes five times in one day. His sexual relationship with his wife, Joan, had diminished largely due to her rage at his increasing sexual demands and his sexual affairs with other women. Part of her response was to overeat so much that she gained over 125 pounds.

Larry also used marijuana and cocaine, ironic considering his intense hatred of his dad's drinking problem, another form of substance abuse. A further irony was that his wife bought the drugs for Larry because, as she later reported, it was better to have him stoned at home than out cruising around.

Larry lived in constant fear of discovery that his children, wife, or church community would find out about the range of his activities. He hated his life and was constantly trying to cope financially to support his sexual activities and drug use.

Venereal disease created a crisis in the marriage, and with the help of their physician, Larry and Joan entered a hospital outpatient program for sexual addiction. Larry found that he was not alone in his problems. Many of the patients had the same or similar issues. In an interview with Larry two-and-a-half years later, upon completion of his treatment, he recounted that there were three main changes in his life since he began treatment. First, his sexuality had shifted dramatically. No longer was he pursuing a desire that he never seemed able to satisfy. Now he and Joan were learning and enjoying sex in different ways than they had believed possible. Second, he had time for work and play. And third, he was no longer living in constant jeopardy of being discovered or running out of money.

In *Out of the Shadows: Understanding Sexual Addiction*, I describe a model (See Figure 1) in which the principle momentum for the addiction in addicts like Larry comes from a personal belief system. This belief system captures all the cultural and familial messages about sex and relationships. When these messages are very sex negative and are coupled with low self esteem, core beliefs about one's own innate shamefulness emerge. Shame is basically a problem of mastery (why is it other kids can do this and I can't?). When the shame is sexual (why is it other people seem to be in control of their sexual feelings and I am not?), the environment for obsessive behavior is at its optimum.

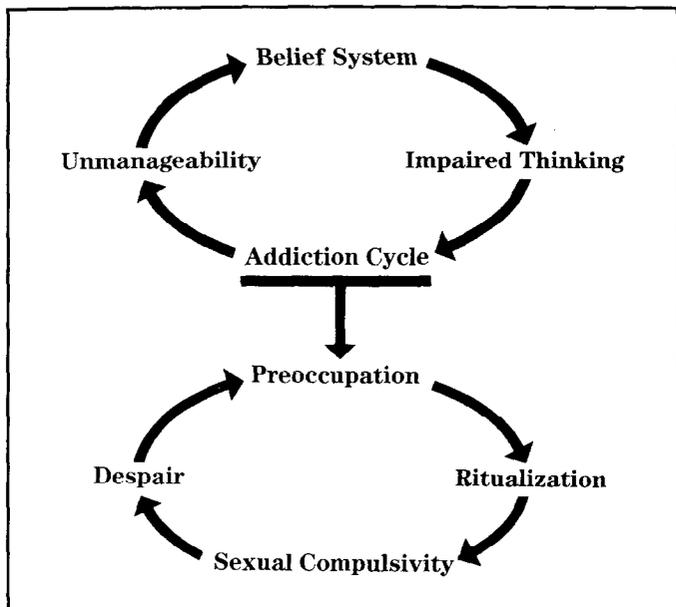


Figure 1. The addictive system.

Source: Carnes, Patrick. *Out of the Shadows: Understanding Sexual Addiction*. Minneapolis, Minn.: Compcare Publications, 1983. Reprinted by permission.

### Impaired Thinking

Through these lenses the addict's thinking becomes impaired, literally, to the point of loss of contact with reality. Addicts talk of entering an altered state parallel to the Jekyll-Hyde shift where even common sense considerations disappear. Denial and delusion govern their lives. One addict, for example, told of following a woman into what he thought was a restaurant only to discover himself standing in the lobby of a police station to which the woman had fled.

Because of the impaired thinking, an addiction cycle perpetuates itself through four phases:

- preoccupation in which the addict enters a trance-like obsession
- ritualization that enhances the trance
- sexual behavior that is often not rewarding
- despair that, once again, the behavior has been repeated

One way to stave off the despair is to start the preoccupation over again. And the cycle becomes the recursive series of events which dominates the addict's life. With this process underway, the addict's life becomes more and more unmanageable, thus confirming the basic feelings of unworthiness that are the core of the addict's belief system.

Larry's secretive life was embedded in this process of shame, powerlessness, and despair. He wanted very much to stop the pain, but the only things that seemed to help were his rituals of indexing his pornography, finding a prostitute, or, when unable to pay for sex, exposing himself. Larry's addictive process presents a very common model familiar to addiction professionals. Shame is a key factor in all addictions. Sexual shame, especially in a sex-negative culture, is particularly virulent.

### Multiple Addictions

Other familiar factors in Larry's case are multiple addictions, both in the addict and his immediate family members. Golden Valley Health Center, a suburban Minneapolis hospi-

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tal, has a twenty bed in-patient treatment program for sexual addiction called the Sexual Dependency Unit. I serve as a program consultant to that facility. Seventy-one percent of the patient population reports multiple addiction or compulsive behaviors. In fact, thirty-eight percent of the program's patients are chemically dependent; another thirty-eight percent have eating disorders. Compulsive gambling, spending, caffeine use, and smoking are also frequent complaints.

The Golden Valley Program represents, in a concrete manner, the emerging recognition among addictionologists that not only do addictions occur concurrently, but in mutually reinforcing ways. Clinicians often observe that the treatment of one addiction will result in the flourishing of another. Patients, for example, who have both alcoholism and sexual addiction often observe that their alcohol use was a way to anesthetize their pain around their out-of-control sexual behavior. They further comment that their alcoholism was relatively easy to deal with compared to their sexual acting out.

Such observations are at odds significantly with the traditional "disease" model of chemical dependency in which alcoholism and drug addiction are perceived as the primary "illness" and the sexual behavior as resulting from it. Unfortunately, there are still alcoholism treatment centers where patients are told that their sexual behavior will straighten out once they get sober.

Major progress is being made, however, in terms of understanding the relationships among the various addictions. One exciting example is the research of Milkman and his colleagues (*Advances in Alcohol and Substance Abuse*, 1983) on the psychobiological impact of hormone interactions on addiction pathology. For their research purposes, they use a matrix developed around three categories of addictions: the arousal addictions (e.g., gambling, sex, stimulant drugs, and high risk behaviors), the satiation addictions (e.g., overeating, depressant drugs, and alcohol), and the fantasy addictions (e.g., psychedelics, marijuana, and mystical/artistic preoccupations). Beyond their research method of categorization, the conceptualization of models of poly-addiction will go far in broadening traditional models of addiction. They will also assist in answering the questions many practitioners have about cross-tolerance effects.

### Family System Theory

Many addiction professionals are using systems theory as a conceptual foundation for their work not only because it is an integrative paradigm but also because it is a *growth versus illness* model. One of the systems identified, for example, by most addiction specialists as key to the self-defeating patterns of the addiction is the family system. Note in Larry's story how other family members had their own addiction patterns (father's drinking and wife's overeating). Observe also Joan's co-participation in the illness through the purchasing of Larry's drugs. Even her weight gain was a statement about their sexuality.

As part of the etiology of the addictive system, extreme family behavior such as extreme rigidity or chaos are common to people who have dependency problems. Further, I describe in a new book now in press a survey of 300 sexual addicts and the incidence of childhood sexual abuse. Sixty-five percent of the women and forty-five percent of the men report having been sexually abused. For a number of reasons I specify in the book, I believe that this is, in fact, underreported.

As part of treatment, the family or significant others are

vital to the recovery process. When Golden Valley Health Center staff conducted six-month post treatment evaluations, they discovered only one common denominator to all the patients who suffered relapse: no family members, partners, or significant others had participated in the family week of treatment.

Systems theory also allows a more organic approach to treatment. For example, comparisons between alcoholism and sexual addiction treatment can create misperceptions about the course of treatment. A better comparison can be made by looking at eating disorders. There are 34 million obese and 14 million morbidly obese persons in the United States. Yet, like sexual addiction, we have been very slow to address this problem. In compulsive overeating, patients are not asked to give up eating, but rather to learn how to eat differently. Eating patterns, environments, foods, and rituals shift so that they enhance rather than destroy the patient's life.

Similarly, sexual addiction treatment helps patients reclaim their sexuality by a primary refocusing of their sexual behavior. Some have assumed that the abstinence focus of alcohol programs has been directly translated to sex addiction programs, and they feared that treatment in these programs would be a sex-negative experience. Of the four hospital based programs I know, treatment staff work very hard to help their patients achieve the goal of sexual enhancement. Part of review criteria for all such programs should include treatment goals that encourage healthy and varied forms of sexual expression.

#### Treatment Outcome

In terms of treatment outcomes, the early six-month evaluation of Golden Valley Health Center patients is encouraging. This internal study of 30 patients has all the obvious limitations of a preliminary study done on the first patient cohort to reach six months. It is also not a large sample, nor is it conducted over a long period of time. Nor were the forms consistently completed. But the information obtained from this preliminary study is positive. For quality of life indicators, patients reported significant improvement in the following areas:

- Family Life 76%
- Job Performance 81%
- General Physical Health 80%
- Self-Image 71%

For program outcomes, patients reported:

- Having no or minimal problems maintaining recovery 86%
- Recommending program to others 100%
- Attending regular or frequent 12-step meetings 76%

The last program outcome requires some explanation. Addiction programs often rely on community support groups based on the 12 steps of Alcoholics Anonymous or as they are translated (e.g., Overeaters Anonymous, Gamblers Anonymous). In the case of sexual addiction, there are a number of groups, such as Sex Addicts Anonymous or Sexaholics Anonymous. The fact that 76 percent of Golden Valley's patients could find local groups is remarkable, given that the majority of them came from all over the United States and Canada. It is a testimony to the rapid expansion of resources for this problem.

#### Conclusion

Some professionals are mistrustful of self-help groups, especially when they have had no experience with them. The fact is they are of uneven quality. However, a good group is hard to beat in terms of helping addicts cope with their shame. The 12 steps are particularly effective with shame-based addic-

tive disorders. Perhaps the best brief explanation of the process is Ernst Kurtz's classic article "Why AA Works" (*Journal of Studies on Alcohol*, 43:38-80) for those readers with no 12-step group experience.

Definitional problems abound in sexual addiction. Eli Coleman elaborates upon them in his companion article to this piece. Questions of normalcy, cross-cultural comparisons, special populations are all familiar terrain to the addiction specialist. In fact, Jim Orford, one of the very first to articulate a theory of sexual dependency, comments in his recent book *Excessive Appetites* (1985):

Debate over definitions in this area is intriguingly reminiscent of debates on the same subject when drug-taking, drinking, or gambling are under discussion. In none of these areas is there agreement about the precise points on the continuum at which normal behaviour, heavy use, problem behaviour, excessive behaviour, "mania" or "ism" are to be distinguished one from another. When reading of the supposed characteristics of the "real nymphomaniac," one is haunted by memories of attempts to define the "real alcoholic" or the "real compulsive gambler."

Current research trends are abandoning the traditional disease oriented typologies in favor of recognizing that natural systems are varied even in pathologies. To find the model "sex addict" that everyone can agree on will take us down a trail the professional addictionologist has been on before. There is not one kind of alcoholic but actually a variety of types who have excessive use of alcohol in common. So I believe that we will find similar patterns in sexual addiction.

The risk is that addiction specialists look skeptically at sex therapists and their lack of training in addictive delusional thought processes and relapse prevention while sexual scientists criticize addictionologists as having inadequate knowledge of sexuality. Meanwhile, people who are struggling with the issue are asking for help. And no progress will be made.

Therein is the opportunity. Some years ago the Italian psychiatrist Mara Palazolli (1981) appealed for professionals to work for what she termed "transdisciplinary" knowledge as contrasted with interdisciplinary efforts in which different specialists focused on a common problem. From her point of view "transdisciplinary" meant creating a new body of knowledge through the cooperation of different disciplines. Sexual addiction presents us with a great challenge and opportunity for addictionologists and sexual scientists to develop the new body of knowledge that Palazolli envisioned.

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**Next Issue . . . September 1986**  
will feature guest editor Janet Rosenzweig on the topic of  
**CHILD SEXUAL ABUSE**

# MORE ON THE SUBJECT

## Sexual Compulsion vs. Sexual Addiction: The Debate Continues

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A client came in to see me a number of years ago and said he didn't know how to explain his problem. After a few false starts, he said, "My brother is an alcoholic. While I'm not an alcoholic, I feel and act just like my brother when he was drinking. Except, I don't drink that much. I don't know if there is a word for it, but I feel like a 'sexaholic'."

Over the past few years, there has been a growing awareness that certain sex behaviors could become an agent for compulsive or addictive disorders. No consensus exists whether these behavior patterns could be described as psychosexual, obsessive-compulsive, impulse, or addictive disorders. How to describe these behavior patterns is still under debate and discussion. What is clear is that a number of people are concerned about the excesses, the lack of control, the amount of preoccupation, and the disruption of their lives by their pattern of sexual behavior.

In response to these concerns, a number of self-help programs and professional treatment programs have emerged, along with books, articles, television coverage, and lively discussions among sexologists and professionals in the addiction field.

The self-help groups, which are rapidly increasing in number, have been designed to help people gain control over destructive patterns of sex behavior. Many of these groups have adopted the 12-step method of Alcoholics Anonymous (AA) in which members are asked to take a first step and acknowledge that they are powerless over alcohol and that their lives have become unmanageable. In Sex Addicts Anonymous (SAA), for example, this first step is simply changed to "We admitted we were powerless over our sexual addiction—that our lives had become unmanageable." The remaining steps from AA remain unchanged. Sex Addicts Anonymous describes itself as "a fellowship of men and women who are committed to a program of spiritual recovery from a life that invited compulsive, uncontrollable, and harmful sexual practices" (Twin Cities SAA, Minneapolis, Minnesota).

There are numerous other self-help organizations with little or no connection to or contact with each other. These groups often differ significantly in philosophy and method, thus, it should not be assumed that one group operates like another, even within the same organization and city. Some of these organizations are: Sex Addicts Anonymous, Sexaholics

Anonymous, Sex and Love Anonymous, and Sex Abusers Anonymous.

Professional treatment programs have also increased in number. These treatment programs, inpatient or outpatient, also differ significantly in their treatment philosophies and methods, including psychoanalytic, social-learning, family systems, cognitive, behavioral, and/or biological treatments. Some programs apply an addiction model borrowed from treatment of alcoholics, while others use treatment models of obsessive-compulsive or impulse control disorders. Some use hormonal therapy, such as depo-provera, an anti-androgenic agent. Some treatment programs distinguish between individuals who are compulsive or addictive sex offenders—rapists, exhibitionists, incest perpetrators, etc.—and those with less social or criminal offenses, such as problematic masturbation or multiple sexual partners. Because all combinations are possible, each program is unique to some degree. There is no consensus on treatment method at present, nor much research demonstrating treatment effectiveness.

### Debate Over Terminology

There has been much debate over terminology, reflecting these philosophical and theoretical differences. The term *sexual addiction* has received the most discussion because it was one of the first of this new terminology popularized by Patrick Carnes' book *The Sexual Addiction*, recently retitled *Out of the Shadows: Understanding Sexual Addiction*. John Money (1985), at Johns Hopkins Hospital and School of Medicine, has indicated that "Carnes is incorrect in calling sex an addiction. It is the object of erotic passion (or the person) to which someone becomes addicted. Analogously, hunger is not an addiction—the addiction is to food, usually carbohydrate." In his book *Love and Love Sickness*, Money (1980) states, "The person who has fallen in love becomes addicted to the love partner—obsessed and preoccupied with the next 'fix' of being together." The danger of describing sex as an addiction is that it presupposes that the individual is addicted to all forms of sexual behavior rather than a specific sexual object or set of sexual behaviors, and following this model, suggests abstinence as a treatment goal.

Others view these behavior patterns as sexual compulsions (Quadland, 1985a, 1985b). Dr. David Barlow (1985) has des-

cribed these as obsessive-compulsive disorders. Others, such as Dr. Andrew Mattison at the Clinical Institute of Human Relationships in San Diego have preferred a non-diagnostic labeling of these behaviors and to simply describe them as problems of sexual control.

There were some attempts in the current revision of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III) to include a new category of psychosexual disorder called "Hyperactive Sexual Desire Disorder." This disorder was defined as sexual desire or activity persistently so high that it interferes with social or occupational functioning, and not occurring only during the course of another Axis I disorder, such as a paraphilia, a manic episode, or substance intoxication. My understanding is that inclusion of this new category has been abandoned.

While sexual scientists debate this question of terminology, my clients seem to be most comfortable with describing their problems as either compulsions or addictions. The importance of debating terminology, however, should not be underestimated. It is critical in truly understanding the nature of these problems and the methods for treatment. And, yet, ultimately, we must acknowledge that we will never find complete unanimity of thought.

### Arguments Against the Addiction Concept

Many concerns and arguments have been made against conceptualization of sex as a potential agent for a compulsive or addictive behavior (e.g., Cushman, 1985; Sharon, 1985; Taylor, 1985; Wedin, 1985a 1985b; and Levine, 1985). The following concerns and arguments have been made by some of the above listed sexologists.

1. This concept can potentially be used to oppress sexual minorities. For example, individuals with multiple sexual partners or same-sex partners may be viewed as compulsives or addicts because they do not conform to the moral values of the prevailing culture (or therapist). With the political swing to the right in sexual morality, the dangers for abuse of this conceptualization is ripe.
2. No matter how one defines sexual compulsivity or addiction, there seems to be an implicit comparison to normalcy of sexual behavior. Thus, the person who masturbates ten times a day is compared with those who masturbate two or three times weekly. While we know that the baseline of sexual behavior is extraordinarily wide, we rarely can agree on what normalcy is. Therefore, the criterion of "number of times" as an indicator of compulsivity or addiction has the potential danger of pathologizing normalcy.
3. If we use global assessment concepts such as preoccupation, out of control, unmanageability, negative consequences, or outside one's value system, we improve upon a definition using only numbers as a criteria but fall into potentially subjective, and value-laden assessments. In the hands of those who hold sex-negative or highly restrictive attitudes about sexuality, this subjectivity can, again, pathologize normalcy.
4. There seems to be no coincidence that the growth of interest in sexual compulsivity or addiction has paralleled the growth of right-wing, conservative and discriminatory attitudes about sexuality and the increase in the dangers of sexually transmitted diseases, such as herpes and AIDS. The argument has been made that mental health professionals using such conceptualizations have become simply instru-

ments of such conservative political views and have made people who do not fit into a narrow, traditional sexual lifestyle feel bad, immoral, and, now mentally ill. For example, a young client came to me and said that he was a sexual addict. When I asked him why he thought this he told me that he masturbated 2-3 times weekly and had been trying to stop for several years. He began worrying about this behavior after he learned that sex could become "addictive." His behavior could be understood as addictive by some or compulsive by others. Or his behavior could be defined as a conflict between conservative sexual attitudes and a misunderstanding of normal or healthy sexual behavior. I chose the latter in treating this individual.

5. "Too much sex can never be too much" (Anonymous). At a recent meeting of the Society for the Scientific Study of Sex (1986), Sol Gordon commented that if you were going to be compulsive about something, let it be sex. He alluded to the fact that this type of compulsivity is far less dangerous than other compulsivities, unless it involves criminal activities.
6. The use of the words addiction or compulsion to describe certain sexual behavior patterns does not exactly fit our current conceptualizations of compulsions or addictions. A better term is needed to describe these behavioral problems or to expand or clarify our understanding of what compulsive or addictive behaviors are. As Stanton Peele (1975) has argued, our conception of addiction has changed over the years and is no longer as physiologically defined. Thus, the use of the word addiction can be expanded to include not only behaviors which are analogous to addictions but are indeed addictions themselves (e.g., love addiction). By strict definition, many of the sexual behaviors of which our clients complain cannot be considered compulsive because compulsion is currently defined as a compelling activity from which the person derives no pleasure. While people who describe themselves as sexual compulsives or addicts commonly experience guilt and remorse over their sexual behavior, they often describe great pleasure before and during the sexual activity itself. So we clearly have some definitional problems.
7. Many people who are treating those with sexual compulsivity or addiction have not been properly trained. For example, addiction professionals too often have simply borrowed from their knowledge of treating alcohol addiction to treat sexual addiction. Often they have had very little or no training in sexual science or sex therapy. Conversely, sex therapists attempting to treat these problems have had little or no training in treating addictions, compulsive behaviors, or impulse disorders.
8. Free use of the words addiction and compulsion have rendered these terms meaningless. The way that some are defining these terms renders the world and all people within as compulsive or addictive. An analogy is the term neurotic, in which descriptions became so broad that no one could escape the label.
9. There is very little research which documents the existence of such a conceptualization. Nor is there much research which documents the effectiveness of treatment methods derived from these concepts.

### Understanding Sexual Compulsion

It is very important in furthering our understanding of sexual compulsivity or addiction that these criticisms and concerns be addressed. In attempting to understand the concerns

of clients who express these types of problems, many psychotherapists have tried to be cautious in not over-diagnosing or falling into the traps the critics have pointed out.

In my own attempt to address these problems, I have cautioned my clients about the problems of labeling and admit our lack of knowledge regarding these problems. However, I am willing to treat people who are in psychological distress because they perceive their sexual behavior as having the elements of preoccupation, lack of control, and destructiveness to their well being or their lives. I prefer to view sexual behavior on a continuum, for every sexual behavior has its healthy aspects and its potential for abuse or compulsion. I prefer the term abusive behavior patterns or compulsivity because there seems to be more uncertainty and potential harm for the use of the term addiction.

### Etiology

The etiology of this still ill-defined set of behaviors is obviously obscure. But in a scientific fashion, I have my own hypotheses based upon existing theoretical notions of compulsivity and addictions and descriptive data based upon my own clinical sample.

In my clinical experience, some type of historical family intimacy dysfunction, such as child abuse or neglect, can be found (See Figure 1). In response to this trauma, the client develops feelings of shame. Because of the lack of established boundaries between parent and child in the egocentric stage of childhood, the client perceives that he was the cause of the abuse—whether it was neglect, physical, psychological, sexual or emotional abuse—and develops feelings of unworthiness and inadequacy (see Kaufman, 1980, for a better description of this process). This feeling of shame results in low self-esteem and an interruption in normal, healthy interpersonal functioning, which leaves the person feeling lonely. All of these events and feelings cause psychological pain for the client, and in order to alleviate this pain, the client begins to search for a “fix,” or an agent which has analgesic qualities to it. For some, this agent is alcohol. For others, it could be drugs, certain sexual behaviors, particular foods, working patterns, gambling behaviors, etc. All seem to cause physical and psychological changes which alleviate the pain and provide a temporary relief. This respite from the psychological pain does not last, and the shame, low self esteem, and loneliness return.

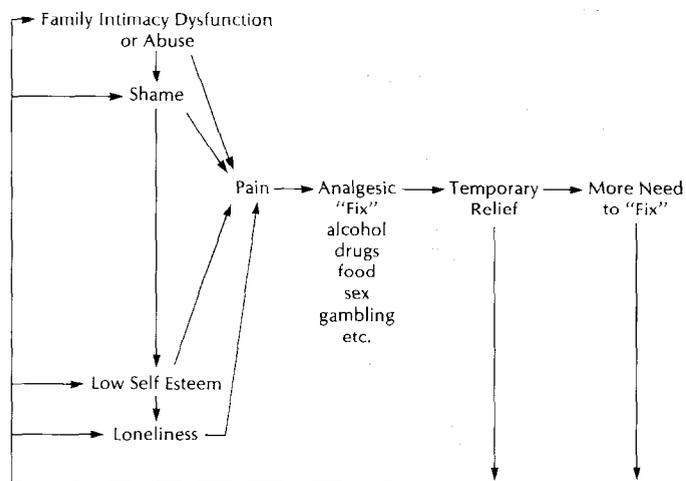


Figure 1. Development of compulsive behavior patterns.

Thus, there is the increased need to return to the temporary relieving fix. The behavior becomes repetitive and forms a vicious cycle that simply feeds a greater need to engage in the behavior for its analgesic qualities. Once the behavior becomes compulsive, this results in further feelings of shame, interference in interpersonal relationships, and intimacy dysfunction. Thus the sexual compulsivity both results from and becomes a symptom of intimacy dysfunction.

Sex as a potential agent for a compulsive behavior is naturally alluring. The sexual response cycle causes significant changes in neuroendocrine and body chemistry. These changes can have adrenalin or analgesic-type qualities. The “natural high” from sexual activity can ease pain, help one relax. It can also mask feelings of pain such as low self esteem. Sex and be used as a “short-cut” to a semblance of positive self-esteem and a feeling of intimacy.

This paradigm of the etiology has been most helpful to me clinically in understanding a variety of compulsive behaviors. The other dynamic which seems most evident in the development of sex compulsive behaviors is the background of highly restrictive and conservative attitudes regarding sexuality (See Figure 2). In response to these environments, my clients have not been able to conform to such restrictive attitudes (usually

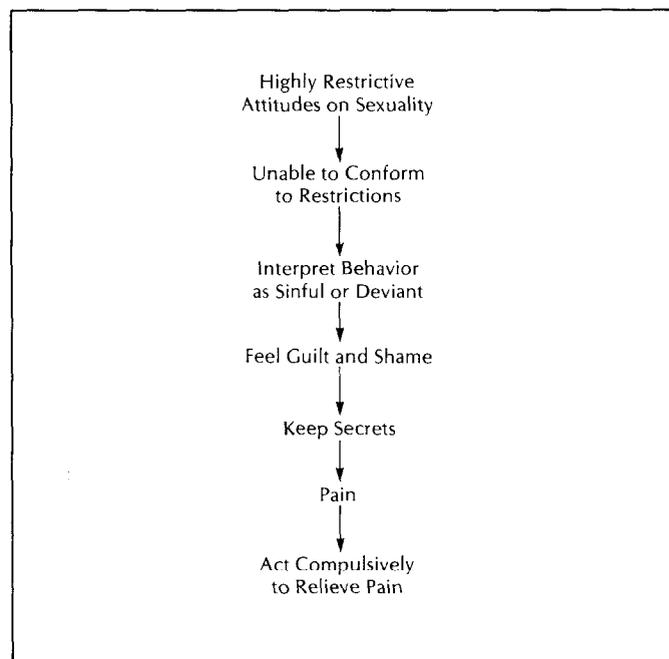


Figure 2. Development of compulsive behaviors through restrictive sexual attitudes.

because they are simply sexual beings). Issues surrounding masturbation, for example, have been commonly traumatic. Many clients report having been severely disciplined for childhood masturbation or carefully watched to prevent masturbation from occurring. Because they could not conform to such restrictions, they cognitively construed themselves as sinful or deviant, resulting in feelings of guilt and shame. Many had already developed shame-based personalities even before sexuality had become an issue. In order to alleviate some of the guilt and shame, they became secretive about their sexual behavior to avoid punishment. This whole process, again, produced psychological pain. The individual, then, acted to alleviate the pain through compulsive behavior patterns. Also, as in most obsessive-compulsive disorders, the more the person

tried to suppress the impulse, the more compelling it became.

These hypotheses are in need of testing. And research is now being conducted. Hopefully, in the near future, there will be some answers.

### Recommendations

Since the concepts of sexual compulsivity and sexual addiction are quite new, I would like to offer a few recommendations:

1. Extensive research should be conducted on the individuals who identify themselves or have been identified by psychotherapists as sexually compulsive or addictive to shed more light on the definitional problems, etiological factors, and treatment methodology. For example, efforts such as Michael Quadland's (1985) research on his theoretical understanding of the problem, treatment methods, and outcome data are quite commendable.
2. Research should distinguish between different types of sexually compulsive or addictive individuals. This could be done according to, for example, Patrick Carnes' four identified levels of sexual addiction.
3. Research should also distinguish the behaviors along a continuum of compulsivity or addictiveness. Possibly distinguishing psychological traits from psychological states might alleviate the problems of seeing people as either compulsive or not or additive or not.
4. Until further research has been completed, we should be cautious in our vocabulary, diagnoses, and definition of the problem. It is appropriate for us to set a framework for understanding and treating individuals who present with concerns or problems related to preoccupation, lack of control, or negative consequences as a result of their sex behavior patterns. We are in no position to be omnipotent in our assertions at this point, and these do not need to be transferred to our clients. This is not to mean that certain philosophies or treatment methods should not be defined and applied. This is the only way that the treatment approach can be described and evaluated.
5. We need to learn about and conduct research on the efforts of the self-help organizations. Professionals tend to have disdain for many self-help organizations because of their lack of professional guidance. And, yet, as we have learned from those who have been members of Alcoholics Anonymous (AA), while not effective with everyone, this self-help group may be just as effective as chemical dependency treatment programs, many of which have incorporated the philosophy and understanding of alcoholism from AA. One of the main concerns I have with the application of the AA model to sexual compulsivity or addiction is that by borrowing so much philosophy from AA, control, abstinence, and a program of spiritual recovery is emphasized, and I don't think this is enough. People can live without alcohol; on the other hand, sexuality is an important and healthy aspect of life. Most groups with which I am familiar help participants separate "addictive" forms of sexual expression and "non-addictive" forms. Therefore, their intention is not to purge sexuality from its members. Without leadership or people with longer terms of "sobriety," these groups often lack positive messages about sexuality. Those who have suffered pain as a result of their sexuality might be reluctant to give permission to other individuals to enjoy sexuality. There needs to be modeling of healthy sexual expression beyond the control of destructive or abusive patterns of sexual behavior.

6. Treatment programs or psychotherapists who treat sexual compulsivity or sexual addiction or problems of sexual control need to be knowledgeable about human sexuality as well as personality disorders, addictive disorders and other forms of mental illness. And, very importantly, the psychotherapists should hold positive and healthy attitudes about their own sexuality and a wide range of sexual expression of others' sexuality. In reviewing my hypothesized etiological factors, conservative or restrictive attitudes about sexuality may be one of the important precursors to sex compulsive behavior. If treatment simply reinforces these attitudes, then the therapist has contributed to the factors which lead the person to act compulsively. Treatment must go beyond control of problematic sexual behavior. First, one must rule out the possibility that the problem is a values conflict between an individual's own expression and societal pressures, and if this is a values conflict, it should be treated accordingly. If not, treatment again should go beyond the control of sexual behavior to help the individual develop positive and healthy attitudes regarding sexuality. In the process of treatment, factors which might contribute to compulsive behavior patterns or inhibit healthy sexual expression should be explored: sexual attitudes, shame, low self esteem, lack of personal boundaries or respect for others' psychological boundaries, sex role discomfort, confusion or dysphoria, concerns about sexual orientation, sexual dysfunction, communication skills, dependency patterns in relationships, and means of expressing intimacy.

### Conclusion

The pioneering efforts of many sexual scientists and other related scientists need to be commended for their efforts at approaching old problems with new solutions. The critics of these new theoretical formulations should also be commended because they have raised serious and legitimate concerns which have forced many of us to sharpen our theoretical thinking, to test our hypotheses through rigorous research, and to avoid the potential dangers which they have outlined.

When I began my career as a sex therapist over ten years ago, I always felt I was in the dark when it came to treating individuals with paraphilias or with compulsive behavior patterns. Giving permission to clients to be sexual beings without feeling guilty and psychoeducative methods of sex therapy were not helpful; nor were behavior modification or psychodynamic methods. The newer approaches which combine methodologies seem to offer more promising results. Yet, we need to document these methodologies and carefully conduct outcome studies based upon our work.

In an effort to increase communication among professionals working in this area and to provide a forum for presentation of theoretical formulations and research data, the Program in Human Sexuality at the University of Minnesota Medical School will be sponsoring a conference in the spring of 1987. This should be a good vehicle for an intensive look at the problem of sexual behavior which develops into obsessive, compulsive, impulsive, or addictive forms. We eagerly await more scholarly work in this important area of human sexuality.

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## DO YOU KNOW THAT...

### SSSS Student Research Grants

The Society for the Scientific Study of Sex awards at least one annual student research grant of \$500. Research conducted by masters or doctoral students is eligible. Those interested should submit a 10-page abstract by September 15, 1986 to: Cynthia E. Jayne, PhD, Society for the Scientific Study of Sex, P.O. Box 29795, Philadelphia, PA 19117.

### Family Resource Movement Conference

On September 12-14, 1986, the Family Resource Coalition is sponsoring a national conference to bring together people and programs involved in prevention-oriented, community-based efforts to strengthen families. Over 80 workshops, seminars and forums will cover a variety of multidisciplinary topics. CEU credits will be available. For more information, contact: the Family Resource Coalition, 230 North Michigan Avenue, #1625, Chicago, IL 60601; (312) 726-4750.

### Progress in Impotence

On September 19-20, 1986, the University of California, San Diego, Medical Center is sponsoring a conference entitled Progress in Impotence: Diagnosis and Therapy. It will be held at the Hotel Intercontinental in San Diego, California. For further information contact: Edith Bookstein, Conference Management Associates, P.O. Box 2586, La Jolla, CA 92038; (619) 454-3212.

## Sexual Addiction Treatment Programs

### OUTPATIENT/SUPPORT GROUPS

COSA: A support group for family members of sex addicts

Twin Cities COSA  
P.O. Box 14537  
Minneapolis, MN 55414

Sex and Love Addicts Anonymous

On the East Coast:	On the West Coast:
SLAA	SLAA
P.O. Box 529	P.O. Box 99429
Newton,	San Francisco,
MA 02258	CA 94109

Sexaholics Anonymous: A recovery program based on the principles of Alcoholics Anonymous; a group start kit is available for \$5 from:

Sexaholics Anonymous  
P.O. Box 300  
Simi Valley, CA 93062

In the New York metropolitan area call: (212) 570-7292

Note: SA also has S-Anon support groups for families of sex addicts.

Sexual Addicts Anonymous  
Twin Cities Sexual Addicts Anonymous  
P.O. Box 3038  
Minneapolis, MN 55403

### INPATIENT PROGRAMS

Sexual Dependency Unit at Golden Valley Health Center: intensive, 4-week, structured inpatient program that incorporates 12 steps of AA and Alanon  
Golden Valley Health Center  
Sexual Dependency Unit  
4101 Golden Valley Road  
Golden Valley, Minnesota 55422  
(612) 588-2771

Sexual Addictions Treatment Program at JoEllen Smith Psychiatric Hospital: intensive 30-day inpatient and 2-week outpatient regimen applying behavior modification and cognitive therapy  
Contact: Stephen Southern (504) 363-7588  
Sexual Addictions Treatment Program  
Clinics for Marital & Sex Therapy  
JoEllen Smith Psychiatric Hospital  
New Orleans, LA

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### THIS SUMMER AMERICANS WANT A SAFE VACATION

If you are planning a summer vacation, you might decide to write your will before you travel.

We hope you will remember to include SIECUS in your will and estate plans, so that, no matter where your travels take you, the issues you care about will continue to have your support.

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80 Fifth Avenue  
New York, New York 10011

HAVE A SAFE AND PLEASURABLE TRIP!

## DO YOU KNOW THAT...

### Resources to Write for . . .

The National Association of State Boards of Education has two 1985 publications recommended for supporters of sexuality education in the schools. **Creating Family Life Education Programs in the Public Schools: A Guide for State Education Policymakers** (32 pages, \$4.00), by Susan N. Wilson, encourages action on the issue of children's need for increased education about sexuality and interpersonal relationships. It includes sections on assessing the need for family life education, assuming state leadership, defining the policy, building support for the policy, listening and responding to the opposition, using the media constructively, and tapping a national support network. **Creating and Implementing Family Life Education in New Jersey** (92 pages, \$10.00), written by Lana Muraskin and Paul A. Jargowsky, is a study of the development and implementation of the state's family life education mandate that took effect in 1983. Findings of case studies undertaken in six local school districts throughout New Jersey are presented. Both publications can be ordered from: NASBE, 701 North Fairfax Street, Suite 340, Alexandria, VA 22314. Prices include p/h.

Creative Child Press has produced a series of children's books for sexual abuse prevention education. There are four coloring books (1985) written by Robin Lenett and Dana Barthelme: **Kids Have Rights Too!, My Body is My Own!, Sometimes It's OK to Tell Secrets!**, and **What You Should Do When...** Also available are a coloring book and an activity book, both published in 1984, entitled **It's OK To Say No!** Each book is priced at \$1.95 and can be ordered from: Playmore and Waldman Publishing Corp., 200 Fifth Avenue, New York, NY 10010.

**School-Based Health Clinics: An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy** (April 1985) is a 24-page report, authored by Douglas Kirby, based on a 1984 conference. An overview of existing programs is given, as well as suggestions for implementation of new programs. Addresses of 17 U.S. school-based clinics are included. Order from: Center for Population Options, 1012 14th Street, N.W., Suite 1200, Washington, D.C. 20005 for \$3.00 (incl. p/h). Bulk rates available.

**Especially for You** (1983) is comprised of two books: **Curriculum Guidelines/Teacher's Manual** (115 pages), and **Student Workbook** (85 pages). Judith L. Keller and Diane Fletcher authored this program for pre-adolescents (ages 9-12), which has been implemented in Virginia. The curriculum addresses human reproduction, physical growth and development, emotional development, and parenthood, including pregnancy prevention. Sample classroom materials for students and parents, a bibliography, and audio-visual and visual aids information are also contained in the teacher's manual. It is priced at \$17.50 (+\$3.00 p/h). The student workbook, which is imaginatively illustrated and organized, is priced at \$4.00 (+\$.75 p/h); bulk rates are available. Order from: EFY Publications, 1107 Colonial Avenue, Norfolk, VA 23507.

**Fathering and Men's Issues Films** (1985), is a 17-page filmography compiled by David Giveans, who plans to update it on a regular basis. In this annotated compilation, 50 films are listed along with names and addresses of their distributors. Single copies are available for \$5.00 from: Nurturing Press, 187 Caselli Avenue, San Francisco, CA 94114. Bulk rates are available on request.

# DO YOU KNOW THAT . . .

## National Conference on AIDS in the Black Community

On July 18, 1986, the National Coalition of Black Lesbians and Gays are sponsoring a conference that will address the public information and education needs of the black community on the subject of AIDS. The conference will be held at the Washington, DC, Convention Center. For more information contact: Gil Gerald, National Coalition of Black Lesbians and Gays, 930 F Street, NW, Suite 514, Washington, DC 20004; (202) 737-5276.

## Child Sexual Abuse: Offenders, Victims & Survivors

A Nicholas Groth, a national expert in the assessment and treatment of both juvenile and adult sex offenders, is offering two workshops addressing the issue of sexual offense. One seminar will consider the dynamics of the offender as well as the impact on the victim, and the other will focus on combating child sexual abuse. They are designed for professionals in mental health, criminal justice, crisis centers, social and protective services and other human services. The workshops will be given in August through October around the country. For more information contact: Dorothy Molis, 29 Linwood Street, Webster, MA 01570; (617) 943-2381 or 943-3581.

## Resources to Write for . . .

**Frontiers in Fertility** (1985) by Betty Rothbart is a 67-page report on the "Symposium on Human Fertility Regulation: Technological Frontiers and Their Implications," convened by the Planned Parenthood Federation of America in December 1984. This book explores the medical, legal, and ethical issues arising from new reproductive technologies. Topics covered include: alternatives in conception, gender selection, fetal diagnosis and fetal therapy, maternal substance abuse, forced Cesarean section, late abortion, and treatment of the seriously ill neonate. Order publication No. 1676 from: Marketing Department, PPFA, 810 Seventh Avenue, New York, NY 10019. Price: \$8.95 (+\$1.50 p/h).

**Straight Talk—Sexuality Education for Parents and Kids 4-7** (1985), by Marilyn Ratner and Susan Chamlin, is a 48-page booklet designed to facilitate communication within the family. It contains sexuality questions and issues raised by parents, in groups and workshops, about their children's sexuality. An 8-page pullout section of activities and projects for 4-7 year olds and their parents is also included. This resource is available for \$4.95 (+\$.80 p/h) from: Education Department, Planned Parenthood of Westchester, 88 East Post Road, White Plains, NY 10601.

**What Is Abortion? Safety of Abortion, Economics of Abortion, and Women Who Have Abortions** are four fact sheets published in 1985 by the National Abortion Federation. They contain up-to-date accurate information about abortion procedures, public health facts, economic issues, and the demographics of women who have abortions. The cost is \$12.50/lot of 50 (same title) plus \$3.00 p/h; bulk rates available. Order from: National Abortion Federation, 900 Pennsylvania Avenue, S.E., Washington, DC 20003.

**Discovery Dolls** are soft sculpture, anatomically accurate dolls similar in style to Cabbage Patch Kids. Standard features include: machine washability and dryability; a name and birth certificate; one complete outfit of clothes including underwear; condoms for males, breasts, bras, and sanitary napkins for adult females, and Velcro detachable pubic and underarm hair. Because each doll is handmade, many other features can be customized, including three choices of flesh color, eye color, clothing, child or adult age, birthmarks, and disabilities. These sturdy, highly appealing dolls are available for \$75.00 each (+p/h and tax) from Monique Felder, 167-44 145th Avenue, Springfield Gardens, NY 11434; (718) 712-2057.

**The Educator's Guide to Preventing Child Sexual Abuse** (1986, edited by Mary Nelson and Kay Clark, is a 210-page collection of 19 original articles by leading professionals in the field of child sexual abuse prevention. Topics include: a history of the prevention movement, guidelines for prevention education, and descriptions of successful prevention programs. Many aspects of child sexual abuse are explored, such as: family relations, community involvement, the school's role, legal problems, the role of the media and advertising, training parents and teachers, children's developmental stages, cultural considerations, disabled children, and theory and research issues. A comprehensive annotated bibliography is included. The price for single copies of this paperbound edition is \$19.95 (+15% p/h); bulk rates are available. Order from: Network Publications, 1700 Mission St., P.O. Box 1830, Santa Cruz, CA 95061-1830.

### Position Opening

The Department of Psychiatry and Human Behavior at Jefferson Medical College announces a position for a Psychiatrist as **Director of Program in Human Sexuality**.

The Program in Human Sexuality is a Clinical Service with a research component focusing on the evaluation and treatment of sexual dysfunctions and infertility problems. It also has an active educational program encompassing all levels, including undergraduate medical students, psychiatric residents, and psychology interns. The position carries administrative, academic, and clinical responsibilities.

For more information please contact:  
Karl Doghramji, M.D. (215) 928-8285  
or  
Arlene Goldman, M.A. (215) 928-8420

## Resources to Write for . . .

**The Dynamics of Relationships** (1985) by Patricia Kramer is a family life education textbook and curriculum for students and teachers. The teacher's manual contains the complete student's text material, plus additional teacher guidelines, activities and recommended print and audio-visual resources. Students using this text need to be at a high reading level. Piloting of this course began in Washington, D.C. high schools for one year in the fall of 1985. Prices of the manuals are: Teacher's Manual (433 pp.), \$23.95; Student's Manual Part I, \$10.95; Student's Manual Part II \$4.95 (with Part I, \$14.95). Include 10% for p/h. Discounts are available on bulk orders. Contact: Equal Partners, 11348 Connecticut Avenue, Kensington, MD 20895, (301) 933-1489.

**The Youthful Sex Offender: The Rationale and Goals of Early Intervention and Treatment** (1985), by Fay Honey Knopp, is a 31-page booklet that includes: guidelines for assessment of behavior and risk, methods of treatment, and recommendations for state planning. It is directed primarily at decision makers. To order send \$5.00 per copy to: Safer Society Press, 3049 East Genesee Street, Syracuse, NY 13224. Bulk rates are available.

**The National Family Life Education Network** has four new pamphlets: **Tell Someone! What to do if someone touches you and you don't like it (grades 5-6)**; **Adult's Guide to Tell Someone!**; **Talking With Your Young Child About Sex**; and **Talking With Your Son About Birth Control. Tell Someone!** is priced at \$.50 for 1-24 copies; each of the others is \$.25 for 1-24 copies (+15% p/h); bulk rates are available on request. Order from: National Family Life Education Network, ETR Associates, 1700 Mission Street, Dept. P., P.O. Box 8506, Santa Cruz, CA 95061-8506.

**Control of Sexually Transmitted Diseases** (110 pages; \$7.00) is a 1985 publication produced by the World Health Organization that emphasizes that control programs must be based on a multidisciplinary approach involving coordinated action by health personnel at all levels and by the health education, information, and welfare services. Attention is given to initial planning steps, intervention strategies, support components, and various aspects of program implementation.

**Family Planning and Sex Education of Young People** (170 pages; \$9.50), and **Sex and Family Planning: How We Teach the Young** (42 pages; \$2.50) are two 1984 publications of the World Health Organization based upon a study on family planning and sex education of young people, with an emphasis on identifying the various strategies used in different countries for providing such services. Single and bulk copies are obtainable in the U.S. by sending the above amounts per copy plus \$1.25 for the first publication and \$.15 for each additional publication to cover postage and handling to: WHO Publications Center USA, 49 Sheridan Ave., Albany, NY 12210; (518) 436-9686. Payment may be made with American Express, Visa, and MasterCard.

**The Birth Control Book** (1986) by Philip A. Belcastro is a 132-page book that describes 13 methods of birth control in laymen's terms and cites advantages and disadvantages for each method. There is also a section on future methods of birth control, some of which are now being tested for FDA approval. To order send \$8.75 per copy to: Jones and Bartlett Publishers, Inc., 20 Park Plaza, Boston, MA 02116; (617) 426-5246.

**The Third Sex: The New Professional Woman** (1986) is a 282-page book by Patricia A. McBroom that focuses on changing gender roles. It is based upon the testimony of 44 professional women in finance in New York and San Francisco and offers a view of the personalities and lifestyles of these women. This book is available for \$16.95 from: William Morrow & Co., 105 Madison Ave., New York, NY 10016.

**It's Up to You: Self-Help for Men with Erection Problems** (1985) by Warwick Williams is a 165-page, self-help book that gives detailed guidance and advice and step-by-step exercises to help restore men's potency. It also covers a variety of treatment methods, and contains a glossary of technical terms and an index. This book is available for \$15.00 from: Williams and Wilkins, 428 E. Preston St., Baltimore, MD 21202.

**Alternate Lifestyles: A Guide to Research Collections on Intentional Communities, Nudism, and Sexual Freedom** (1985) by Jefferson P. Selth is a 133-page bibliography that describes in detail 36 special collections in the U.S. that are rich in published and unpublished research materials in the fields of intentional communities (communes), nudism, and sexual behavior, especially sexual freedom. This book is available for \$29.95 from: Greenwood Press, 88 Post Road West, Box 5007, Westport, CT 06881; (203) 226-3571.

**The Redundant Male: Is Sex Irrelevant in the Modern World?** (1984) by Jeremy Chermas and John Gribbin is a 196-page book that explains the biology of sex and sexuality and challenges patriarchal beliefs about the dominance of the male. This book highlights new areas of technological ability and suggests that the technology for asexual reproduction is not far off. It is available for \$7.95 (paperback) from Random House, New York, NY.

**Erotic Power: An Exploration of Dominance and Submission** (1985) by Gini Graham Scott is a 250-page book that describes the growing dominance and submission (D&S) movement. Through interviews and eyewitness accounts, the author offers an overview of D&S, which includes both sadomasochism (S&M) and bondage and discipline (B&D). This book is available in paperback for \$9.95 from: Citadel Press, 120 Enterprise Ave., Secaucus, NJ 07094; (212) 736-1141 or (201) 866-0490.

**Handbook of Feminist Therapy** (1985) edited by Lynne Bravo Rosewater and Lenore E. A. Walker is a 352-page anthology that covers psychotherapy, assertiveness training, heterosexual and homosexual relationships, sex therapy, and pornography, as well as other therapeutic issues. This clothbound book is available for \$34.95 from Springer Publishing Co., New York, NY.

# AUDIO-VISUAL REVIEWS

Members of the Audio-Visual Review Panel for this issue were: Rita Cotterly, graduate assistant, SIECUS Information Service and Mary S. Calderone Library, and doctoral candidate, Human Sexuality Program, New York University; Marianne Glasel, RN, MS, education coordinator for Cancer Prevention and Sexual Health Care, Memorial-Sloan Kettering Cancer Center, and student, Human Sexuality Program, New York University; Leigh Hallingby, MSW, MS, Manager, SIECUS Information Service and Mary S. Calderone Library; William Li, intern, Department of Education, Planned Parenthood Federation of America; Maria Matthews health educator, Planned Parenthood of Bergen County, Hackensack, NJ; Alex Sareyan, president, Mental Health Materials Center; Linda Schwarz, Department of Education, Planned Parenthood Federation of America; and George Marshall Worthington, international health and development consultant, New York, NY. The reviews were written by Leigh Hallingby.

**AIDS: What Everyone Needs to Know.** 1986, 16 mm or video, 18 min. Purchase, \$350 (16 mm), \$250 (video); rental, \$40. Churchill Films, 662 North Robertson Boulevard, Los Angeles, CA 90069; (800) 334-1830.

This film surveys the facts and debunks the myths about AIDS. Through the use of animation the film explains how the immune system works and how the AIDS virus destroys the system's ability to fight off diseases. Symptoms and related diseases are presented. *AIDS: What Everyone Needs to Know* also describes how the virus is and is not transmitted, why casual contact with AIDS patients is not dangerous, who is at highest risk, and how to protect oneself from the virus. Woven through the factual material are clips of an interview with an

AIDS patient, who is a former drug abuser, and his wife.

On the plus side, this film gives much good information and dispels several myths about AIDS. On the minus side, it has a scary, alarmist quality, promulgated largely by the type of background music selected and the heavy use of the color red in the graphics. Sometimes the visuals do not match the commentary well, such as a close-up of the pelvic area of a person wearing jeans shown during a reference to the lining of the sex organs. The narrator states that children of high risk group members are also at risk, without specifying that this means children born to or breastfeeding from women who already have AIDS. It was clear only from the study guide and not from the film that the persons with AIDS and the woman being interviewed with him were husband and wife rather than patient and health professional.

Some members of the panel felt the negatives outweighed the positives and would therefore not recommend this film for use without any audience. Others felt that it gave enough good information that they would use it with audiences from early teens up. **ET, LT, A**

**Chance of a Lifetime.** 1986, video, 43 min. Available for purchase for \$50 to professionals doing AIDS prevention education. AIDS Prevention Program, Gay Men's Health Crisis, Box 274, 132 West 24th Street, New York, NY 10011; (212) 807-7517.

This superb video is designed to be part of safer sex workshops for gay and bisexual men. It begins with a brief written statement of guidelines for safer sex and then consists of three vignettes. The first involves two men, one black and one white, on their fourth date, making love for the first time. The anxiety regarding

broaching the subject of safer sex before becoming sexually involved is handled with a sense of humor and the dialogue that ensues is a good example for communication on this topic. An erotic bath together precedes their love-making scene.

The second segment is an anonymous sexual encounter between two leather-clad men in an S & M bar. Being shown in the bar is another GMHC-produced video called "Grey Hideaway" in which a group of men are engaging in safer sex, including oral sex with a condom. The two men rough house and use some S & M devices, taking time out to wash their genitals and roll on a condom before having anal intercourse.

In the third and very moving vignette, two men who seem to be involved in a long-term relationship make love outdoors by the swimming pool in their backyard. One is a tanned jogger and the other, who is rather pale, is obviously a person with AIDS, indicated by references to his beginning to get his strength back after being in the hospital for pneumonia. Their love-making is playful and in part they act out a fantasy of a marshall giving orders to a cowboy. The scene ends poignantly with one singing to the other the verse from the old cowboy song that says, "I will miss your bright eyes and sweet smile."

One could quarrel with small points in *Chance of a Lifetime* such as not including some older actors and not showing how to remove a condom. However, the choice of situations is excellent, as are the acting and the production values, and the video is highly recommended for the intended audience. Some panel members also felt that, if it were to become more widely available, it would be an excellent film to use in Sexual Attitude Reassessment workshops for sensitization regarding gay male relationships and lovemaking. *Chance of a Lifetime* succeeds mightily not just in educating about safer sex, but also in eroticizing it. **A.**

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Audience Level Indicators: **C**—Children (elementary grades), **ET**—Early teens (junior high), **LT**—Late teens (senior high), **A**—College, general adult public, **P**—Parents, **PR**—Professionals.

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**Taking a Sexual History.** 1986, video, 18 min. Purchase, \$250. Sunrose Associates, 18 Cogswell Avenue, Cambridge, MA 02140; (617) 575-3863.

*Taking a Sexual History* by Marian Glasgow, adjunct assistant professor, Boston University School of Medicine, is a videotaped lecture that addresses a group of health professionals. This resource presents a good, broad definition of sexuality and a rationale for asking questions regarding sexuality during health care evaluations. The highlight of the video is the presentation of the Glasgow Short Form Assessment of Sexual Health, with accompanying instruction on how to integrate the most essential questions about sexual functioning into a review of systems. Also included is a question and answer session with the audience about the barriers to discussing sexuality in a health care setting.

The Glasgow Short Form (printed in its entirety in the accompanying study guide) is brief, consisting of two questions each for males and females, three for both sexes, and six to clarify problems. Examples of the questions are: Do you have any problems having or maintaining an erection? Do you have any pain during vaginal penetration? How has your present illness affected your sexual functioning? The panel's major concern with the form is that although Ms. Glasgow defined sexuality broadly in terms of who we are as men and women, her questions focus totally on genital sexual functioning. She completely omits the potential effects of hospitalization/illness/treatment on sex role and sexual identity. Questions such as: "How has your mastectomy affected your feelings about yourself as a woman?" or "How does your not being able to work now make you feel about yourself as a man/woman?" are not asked.

Ms. Glasgow is a warm, appealing presenter, and despite the lecture format, the video holds interest and attention. It does not have a heterosexist bias. *Taking a Sexual History* is definitely recommended for professional audiences but cannot and should not stand on its own. It needs to be part of a session covering both how to raise questions about other non-physiological aspects of sexuality and also how to handle information from patients regarding sexual concerns and problems once it has been elicited. **PR**

**VD: More Bugs, More Problems.** 1985, 16 mm or video, 20 min. Purchase \$440 (16 mm), \$390 (video); rental, \$44. Alfred Higgins Productions, 9100 Sunset Boulevard, Los Angeles, CA 90069; (213) 272-6500.

This update of an earlier film entitled "VD: Old Bugs, New Problems" covers gonorrhea, syphilis, herpes, chlamydia, AIDS, candidiasis, crabs, scabies, warts, and trichomoniasis. Much of the information is conveyed by people talking on the telephone in a simulated STD hotline situation, and what they are saying is clearly oriented toward young people.

Unfortunately, the panel found this to be a lackluster film plagued by poor acting and a thrown-together quality. It does not mention oral or anal sex as a cause of STDs and covers neither proper condom usage nor talking to one's partner about having an STD. For these reasons a few panel members said that they would not recommend it for any audience. Others said they would use it for adolescents in conjunction with considerable supplementary discussion from a facilitator. **ET, LT**

## Choices: In Sexuality with Physical Disability

(16 mm & Video/Color/60 Mins.)

Produced for:  
Institute of Rehabilitation Medicine  
New York University Medical Center  
Joan L. Bardach Ph.D., Project Director  
Frank Padrone Ph.D., Co-Director

... Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed...

**Pam Boyle, Coordinator:** Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood, NYC.

# MERCURY

Mercury Productions  
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**Terrific Sex.** 1985, video, 60 min. Available for sale and rental in home video stores.

This video, oriented toward the home market, begins with an upbeat introduction in which Dr. Ruth Westheimer says that terrific sex comes from a good relationship, depends on openness, and should be fun. She then goes on to give 18 commandments for terrific sex ranging from "Don't make love on your first date" to "Don't fake orgasm" to "Stay within the guidelines of your personal beliefs." Some commandments involve Dr. Ruth giving her thoughts on such topics as masturbation, foreplay, positions for intercourse, orgasm, afterplay, and fantasy. Two involve her conducting simulated therapy sessions—one with a woman who cannot have orgasm with a partner and one with a man who is a rapid ejaculator.

With minor exceptions, Dr. Ruth does an excellent job of covering the basics of giving and receiving sexual pleasure in a holistic, permission-giving, and helpful way from which the vast majority of heterosexuals (her target audience in this video) could clearly benefit. Many people might prefer to watch *Terrific Sex* in segments rather than all at once, although the producers have done a good job of varying a basic "talking heads" format by having Dr. Ruth give some of her commandments while jogging, gardening, riding a bicycle, swinging on a swing, driving a sports car, and walking in the rain. Because the video does not seem to lend itself particularly well to repeated viewing, rental is recommended for consumers, although professionals may wish to purchase it. **A**

**AIDS Alert.** 1985, video, 23 min. Purchase, \$149.95. Health Alert Division, Creative Media Group, 123 Fourth Street, N.W., Charlottesville, VA 22901; (804) 296-6138.

This video begins with a nine-minute introduction by Dr. Richard Keeling, chairperson of a national AIDS task force, in which he explains why "we all need to know about AIDS." Following the introduction, which seems to be oriented toward adult audiences, is an animated section which is actually a filmstrip or videotape. In it Dr. Goodhealth, a Gumby-like character, answers questions from an audience of cartoon characters based on the male and female

sex symbols. He describes what AIDS is, how it is caused and transmitted, what the symptoms are, and how people can reduce the risk of getting AIDS. Dr. Keeling concludes the video with a brief statement that puts responsibility for avoiding transmission of AIDS in the hands of the individual.

The panel liked *AIDS Alert* for the most part, feeling that it is informative without being alarmist. The cartoon characters are, in fact, specifically designed by their creator, Charles Chic Thompson, to be anxiety-reducing, and they seem successful in that regard. Also, the use of video format for the animated filmstrip is a relatively inexpensive way to keep down the price of the finished product. On the negative side, however, the format is not particularly interesting or engaging and some audiences may be bored by it. Other criticisms from panel members included disliking a reference to the HTLV-III antibody test as a diagnostic tool for AIDS and finding the narrator to be condescending.

*AIDS Alert* is recommended for audiences from early teens through adults, with the suggestion that educators omit the doctor's introduction. **ET, LT, A**

**Communicating, with Dr. Jessie Potter.** 1986, 16 mm or video, 28 min. Purchase, \$475 (16mm), \$430 (video); rental, \$75.00. Sterling Productions, 1609 Sherman, Suite 201, Evanston, IL 60201; (312) 475-4445.

After the Audio-Visual Review Panel saw Dr. Potter's previous film, "The Touch Film . . ." one member summed up our reaction when she said, "Every person on earth should be required to see this film." Our recommendation regarding "Communicating . . ." is the same. Once again Dr. Potter—in her wise, warm, and witty way—has managed to take a universal issue and make it into a beautiful film filled with sound advice and wonderful examples to which everyone can relate.

Some of Dr. Potter's many points are: we should identify feelings and talk about them; hurt feelings and misunderstandings result when there is no communication; communication can save relationships; others cannot know what is on our minds unless we articulate it; blocked communication is a major factor in adolescent suicide; and we should communicate about sexuality using

proper names for the genital parts of the body. Examples used for illustration include vignettes of everyday situations involving wife and husband, parent and child, grandparent and grandchildren, doctor and patient, and employer and employee. Particularly helpful are the instances in which a miscommunication is followed by successful communication by the same people on the same topic.

Dr. Potter does not hesitate to point out that there is always a risk of rejection involved in reaching out to communicate with someone. Yet no viewer could walk away from this film without realizing that the ability to communicate is empowering and enriching and well worth the effort. **C, ET, LT, A, P, PR**

**Personal Decisions.** 1986, 16 mm or video, 30 min. Purchase, \$395 (16 mm), \$295 (video); rental, \$50. Cinema Guild, 1697 Broadway, New York, NY 10019; (212) 246-5522.

In this fine film, produced for the Planned Parenthood Federation of America, seven real-life stories are woven around the central thesis that the decision to have an abortion is a strictly personal one. The participants include: a waitress who, after a brutal rape in the 1950's, suffered the indignities and medical complications of an illegal abortion; a 16-year-old high school student not ready for motherhood; a couple who were looking forward to the birth of their second child until they discovered through amniocentesis that the fetus was seriously deformed; an obstetrician who found herself pregnant as a result of contraceptive failure in her first year of medical school; an abused wife and mother of three who discovered during the course of separating from her husband that she was pregnant again, and a Catholic college student who had to go from door to door in her neighborhood to borrow money for the abortion.

The women in *Personal Decisions* represent an excellent mix of age, ethnicity, socio-economic status, religion, and reasons for choosing abortion. Their powerful stories, filled with poignancy and pain, are as eloquent testimony as there could be in support of abortion as a personal decision. Also appearing in the film to discuss the abortion issue in a very sensitive manner is Dr. Kenneth Edelin, director of OB-GYN at Boston City Hospital, who does not however tell

his own tale of arrest and conviction (subsequently overturned) for performing an abortion. This film is highly recommended for all audiences from early teens up. **ET, LT, A, P, PR**

**Young Fathers/Teenage Love.** 1984, 12 min., video. Purchase, \$245; rental, \$30. Educational Cable Consortium, 24 Beechwood Road, Summit, NJ 07901; (201) 277-2870, or New Dimension Films, 85895 Lorane Highway, Eugene, OR 94705; (503) 484-7125.

This short film, taken from an NBC documentary, looks at the lives of two teenage boys who became fathers. A young white man from Salt Lake City, Utah, lives with his fiancé, baby, and very supportive parents. He goes to school, works from 8 p.m. to 4 a.m., and is exhausted. A young black man from Philadelphia is no longer involved with his child's mother, but is very attached to the baby. He had dropped out of school, but has returned, because the baby has given his life a sense of purpose.

The panel found some important pluses in this brief documentary. It presents a positive image of teenage boys (something many audio-visuals do not do), showing them making sacrifices for their babies, with whom they are actively involved. It is a good length for educators working with groups of adolescents or parents, because it allows plenty of time for discussion, of which it should generate plenty. One minus is that, although abortion is mentioned as an alternative, contraception is not discussed; so this subject should be raised during the discussion period. **ET, LT, P**

### Memo to New Readers

The *SIECUS Report* is published bi-monthly and distributed to SIECUS members. If you are not already a member and you wish to have continued access, through the *SIECUS Report* and other organizational publications and services, to authoritative, up-to-date information about all aspects of the human sexuality field, please send us your name and address, along with the appropriate fee as shown in the masthead box on page 2 of this issue. Be sure to indicate the category of membership desired.

# BOOK REVIEWS

**Safestud: The Safesex Chronicles of Max Enander** by Max Enander (127 pp., \$6.95) and **Hot Living: Erotic Stories About Safer Sex** edited by John Preston (191 pp., \$7.95). Boston: Alyson Publications, 1985.

*Reviewed by Michael C. Quadland, PhD, psychologist in private practice and sex education consultant, New York State AIDS Institute on AIDS prevention; and John Weir, writer, and leader, Gay Men's Health Crisis Writer's Group.*

Safe sex practices have begun to make some headway into gay male pornography. What is new, or different, about safe sex porno? Most importantly, of course, the sexual acts must be limited to what is generally considered safe: non-exchange of bodily fluids, especially semen (with some disagreement among health care professionals about saliva); anal and oral sex can be practiced safely only with condoms. The problem of how to continue to have satisfying sex that is reasonably safe is central to two new books from Alyson Publications, Max Enander's *Safestud: The Safesex Chronicles of Max Enander*, and *Hot Living: Erotic Stories About Safer Sex*, edited by John Preston.

Post-AIDS sex, with some imagination, can still be exciting, Max Enander concludes, in *Safestud*. Max describes himself exclusively in terms of his sexual appetite and large genitals. He constantly reminds the reader, and himself, exactly what is important to him about sex. He lives in San Francisco, works in a bank, and likes a lot of casual, uncommitted sex. He has two gay roommates who are sometime lovers; he has one friend named Chad, who spends most of the time disappearing into the clutches of his Safe Sex Master, Lord Dennis. Max is comfortably urban-white-middle class: he does a lot of reading and goes to the movies, gets away to Yellowstone Park, spends time at the beach, and spends his holidays alone, except when he is having sex. He does not have much to say about

his job, or his apartment, or his social life, which is practically nil. Max's social life, indeed his entire life, is focused on having sex, judging from *Safestud*, which, to be fair, is his "sexual" diary. Throughout the book, he has countless sexual encounters with all kinds of nameless men, most of whom have massively erect penises and washboard stomachs. Indeed, two idealized, overworked bodies adorn the cover of *Safestud*; hipless, bare-chested, broad shouldered fantasies, with creamy white skin and perfectly formed buttocks. *Safestud* delivers what its cover promises: hot fantasies and horny males, all of it exaggeratedly "good," but also safe in terms of AIDS prevention.

This could easily be pre-AIDS material, with the condom as the only unfamiliar presence, except that Max does not seem happy, not exactly. When he is not completely absorbed in pursuing and recording his sexual adventures, he pauses to deliver long asides on the emotional perils of his sexual lifestyle. His life lacks passion, he concludes, and it lacks a relationship. Max has been in love only once, as a teenager; his lover dumped him, and he will not be hurt again. Sex is his substitute for love, he says; he even figures out that his sexual encounters, taken collectively, constitute an extended, 10 year-long relationship. Towards the end of his chronicles he does develop a couple of long-term involvements, one with Paul, a sex-buddy, and the other with Eddie, a potential life mate. Still, Max continues to have as much sex as he wants with as many different men as he can find. He does not always seem to enjoy it, not because it is safe sex, but because it is uncommitted sex; he wants to feel a sense of connectedness with his sexual partners. Yet when he is on the verge of making a commitment to Eddie he pulls back, again. While Max's sexual exploits may be safe, they are proof that safe sex can be just as lonely, and as frequently unsatisfying, as unsafe sex. **A**

*Hot Living*, a collection of short stories concerning safe sex, offers a number of different perspectives on sex in the age of AIDS, without coming up with a fresh point of view. Here, as in *Safestud*, the action focuses on hot, anonymous encounters among exclusively Anglo-American men with large genitals. Among the seventeen stories included in the volume, many deal with the ways in which gay men have had to change their lives as well as their sexual habits in order to deal with AIDS, but none seem up to the challenge of reimagining gay sexuality.

The tone of *Hot Living* is mournful. The volume opens with a story concerning a man who has lost the use of his lower body in an automobile accident. An old friend comes by and helps him to have an orgasm, which he cannot exactly feel; it is a "phantom feeling" only, a remembered sensation. This story is called "The Broken Vessel," which expresses clearly enough the feeling among gay men that AIDS has literally disabled them sexually. Certainly this is an important issue within the gay community, but it hardly seems right as the opening stroke for a book that means to eroticize safe sex.

About half the stories in the collection strike this note, however: "I was in the prime of life, had worked hard to get there, and was shadowed by a perilous age that haunted me and others of my kind," says a character in Tripp Vanderford's "The New Cosmic Consciousness." The title is misleading, for the story does not offer a new consciousness at all, not about sex. It focuses on regret, and a sense of loss, as well as on the protagonist's passion for a classically modeled young stud at the gym. Predictably, the stud turns out to have the same large penis and washboard stomach as every other male in the book, whose body parades past the reader's impressionable libido. Safe sex is just like unsafe sex, focused on perfect bodies and large genitals, in spirit, if not in action.

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*Audience Level Indicators:* **C**—Children (elementary grades), **ET**—Early teens (junior high), **LT**—Late teens (senior high), **A**—College, general adult public, **P**—Parents, **PR**—Professionals.

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*Hot Living* is a lament for a time gone by, for fifties Boyd MacDonal sex, for nameless, limitless, unrestricted sexual encounters. A lot of gay men miss that era, according to the voices in *Hot Living*; perhaps this first phase of safe-sex porno is a period of mourning, of looking back to the past before fully imagining the future. It would be a shame at this point in gay history to get hung up on the sexual loss, however, and overlook the opportunity to discover aspects of sexuality that do not press gay men exclusively into casual, sexually exploitative relationships with each other. Both *Hot Living* and *Safestud* fail to imagine safe sex that is particularly innovative, creative, or different from unsafe sex. The books offer nothing new; just the same group of urban-white men going to the gym for an ogle and a grapple in the steam room. A

**Solutions.** Leslie Cameron-Bandler. San Rafael, Calif.: Future Pace, Inc., 1985 (259 pp., \$11.95).

Reviewed by Jean S. Gochros, PhD, AASECT Certified Sex Educator and Therapist in private practice; author, *What to Say After You Clear Your Throat: A Parent's Guide to Sex Education, The Sexually Oppressed, and Helping the Sexually Oppressed.*

It is a rare but immensely satisfying experience to review a book that does for clinicians exactly what it purports to do. Cameron-Bandler promises to explain and apply a relatively new therapeutic model, Neuro-Linguistic Programming (NLP), to help people enjoy satisfying couple, including sexual, relationships. She promises to translate theory into assessment and treatment plans; to provide step-by-step demonstration of NLP techniques; to show how to know whether a given goal has been reached during the interview; and how to help clients repeat that success after leaving the interview. Finally, she promises to make her concepts understandable and useful to professional and lay leaders alike.

In fulfilling these promises, she brings new dimensions to marital and sexual counseling and to such concepts as *love*, *empathy*, and *non-verbal communication*. She skillfully leads readers through her therapeutic process, demonstrating such new techniques as Erickson's storytelling and NLP's *anchoring* and *reframing*. She makes her concepts immediate-

ly testable and applicable by asking readers to test a concept on themselves or apply a given technique to situations in their own lives. I, personally, complied for only a minute or so. Yet in one instance I gained a new perspective leading to a deliberate behavioral change. In another, a new perspective was followed hours later by an indirectly but obviously related and desirable change in physiological response to a certain stimulus. One could hardly ask for a better demonstration of NLP's potential power or the effectiveness of Cameron-Bandler's presentation.

*Solutions* is not, however, flawless. For one thing, it is aimed at both professional and lay markets, but is essentially a clinician's handbook and should be labeled as such; for another, many nonverbal communications may be culturally defined. In her few references to culture, it is unclear whether the author is asking for reader attention to cultural variations or suggesting that her content is universally applicable.

Two small additions seem needed. The visual aid of a chart for assessing eye movement is stressed as applying to right-handed people. Are directions to be reversed for the left-handed? An added statement and chart might have been useful. Similarly, the author frequently mentions touching a client's *right* or *left* side, but does not state whether the choice of sides is purposeful. Elaboration would have been helpful.

More hazardous weaknesses are the implications that all intrapsychic and interpersonal problems are created by clients' own perceptual distortions and subsequent dysfunctional behaviors, that they are always within the individual's power to correct, and that NLP procedures alone are sufficient to help clients reach their goals. The professions of social work and sociology have provided ample evidence that such assumptions are unrealistic. Institutionalized racism and sexism, for example, create and maintain many problems, often affect marital and sexual relationships, and can even thwart individual attempts to change dysfunctional behavior. Cameron-Bandler dismisses socio-political, economic realities in such statements as: "It is not the world that lacks choices, but the individual's model of the world (p. 224)," and, "A basic premise of my work is that people have all the resources they need to make the changes they want and need to make. . . .

Whether or not this is true, . . . when I structure my behavior as if it is true, the results provide . . . testimony to its usefulness (p. 131)."

This seems an unfortunate way to deal with the need to realistically limit and focus therapy. At base it reflects the medical model the author decries, in which clients' perceptions are by definition "pathological" and therapists' are "healthy." Indeed, it is the same "blame the victim" stance rightfully under attack by feminists, gays, and other civil rights groups.

Perhaps this explains the uncharacteristic times in sample interviews when her use of NLP techniques seems to contradict the respect, accurate empathy, restraint, flexibility, and parsimony she advocates. At such times the author seems to ignore or miss important communications, to make unwarranted assumptions, and to treat patients without adequate information. Her therapeutic decisions may have been correct, but since she has departed from her usual style of sharing her thinking with readers, one is left with unanswered questions.

Some ethical issues in her approach must also be raised. In one transcribed initial interview, she ignores the client's obvious wish for information about NLP and simply begins to use such techniques as *anchoring* through specific touch. In marital counseling, having anchored a wife's sexual response to a certain touch, she instructs the husband—without the wife's knowledge—to use the touch to communicate sexual desire. She treats a student/client covertly, illustrating the use of metaphor in a class seminar with a metaphor aimed directly at him. Her success is verified when he tells her later that he does not need therapy after all, since he has suddenly found his own solution.

Cameron-Bandler argues that any effective technique used for the client's good is ethical. However, clients do have the right to know in advance what a given therapy might entail, to be involved in the treatment planning, and to have some say in what techniques will be used. They have the right to expect therapists to work *with* them in a joint problem-solving effort, rather than therapists deciding what is good for them and doing things to them without their knowledge.

Neither *Solutions* nor NLP (nor any other theory, author, or book) should be used solely or unquestioningly. Indeed, one would hope that as one of NLP's origi-

nators, Cameron-Bandler will reexamine some of her tenets and make better use of the knowledge provided by other professions. Despite these shortcomings, *Solutions* is a concise, useful, and thought-provoking book that can be highly recommended to all clinicians, no matter what their specialty. PR

**Sexuality and Its Discontents: Meanings, Myths and Modern Sexualities.** Jeffrey Weeks. London: Routledge & Kegan Paul, 1985 (324 pp.; \$25.00 hardcover, \$13.95 paperback).

*Reviewed by Carol A. Pollis, Ph.D., Associate Professor of Sociology, Social Change and Development Program, University of Wisconsin-Green Bay, Green Bay, Wisconsin.*

The British social historian Jeffrey Weeks has written extensively on the theory, history, and politics of sexuality. This new book, coupled with his earlier *Coming Out* (1977) and *Sex, Politics and Society* (1981), completes an unplanned trilogy on the social organization of sexuality in the modern era and makes a significant contribution to defining one variant of the social constructionist approach to sexuality. A fundamental assumption of this approach is that there is no natural or essential sexuality which transcends history, but only historically grounded concepts and systems of knowledge which define a sexual nature or essence. Sexuality and the present importance assigned to it are not determined by biology—though there is the physical body and its possibilities for pleasure—but by the individual and collectively generated definitions which constitute it.

*Sexuality and Its Discontents*, which expands themes developed in an earlier essay by the author, analyzes the complex ways sexual theory and sexual politics have interacted to produce and change the “historical invention” of sexuality. The heart of the book discusses the organizing and limiting functions of scientific sexological discourse over the past century and recent feminist and gay movements of affirmation which have produced a “grass-roots sexology” to challenge such discourse. The primary goal of this discussion is to present a case for a radical pluralist position concerning sexual politics, a position which advocates a conception of history as politics directed to building an economic, cultural, and sexual democracy.

In Part I, “Sexuality and Its Discon-

tents,” Weeks convincingly argues that current discontents, reflected by the multiplicity of interpretations and values around sexuality, frame a crisis in late capitalist societies of the West. The roots of this crisis are located in the failure of the sexual revolution commencing in the 1960s to generate gender equality and freedom of sexual choice. Four changes which have shaped the current situation of crisis are discussed: the commercialization of sex, shifting and increasingly problematic relations between the sexes, the (uneven) liberalization of laws regulating sex, and the appearance of intensified social antagonisms around sexual issues. Particular attention is paid to the resurgence, during the 1970s, of an absolutist politics based on the moralism of the New Right.

Part II, “The Sexual Tradition,” examines the role which scientific sexology has played in constructing the myths, meanings, and crisis of modern sexualities. Weeks draws heavily on the work of French philosopher-historian Michel Foucault in presenting a position which focuses on the positive power of sexologists to create sexuality. Like Foucault, he is interested in how sexologists, operating within the privileged status of science, have defined the truth of sex so as “to naturalize sexual patterns and identities and thus obscure their historical genealogy.” The ideas referenced in support of this position are those of: early sexologists who assumed a sexual essence, anthropologists who saw cultural regulation as critical but whose ahistorical cultural relativism did not challenge the concept of a sexual nature, and recent sociobiologists concerned with “the biological mechanisms that provide the basis of social phenomena.” Unfortunately, little is said about how the vast quantity of post-Kinsey empirical research fits into this thesis. Such silence weakens an otherwise much-needed appraisal of the power exercised through sexological discourse.

Part III, “The Challenge of the Unconscious,” takes up the psychoanalytic tradition within sexological discourse, a tradition barely mentioned in Part II. Unlike many contemporary theorists who have rejected Freud, Weeks emphasizes the radical impulse within Freudian theory and the role a dynamic unconscious plays in linking the individual to social forms which shape sexual expression. He favors a reading of Freud, developed by French psychoanalyst Jacques Lacan and fruitfully appropriated and adapted by feminist thinkers such as Juliet Mitchell

and Nancy Chodorow, which renders an account of how gender and sexual identities are constructed within the linguistic order of the unconscious. In this reading, the unconscious is cut away from a deterministic biology and “becomes the way in which we acquire the rules of culture through the acquisition of language.” The second chapter in Part III weaves together ideas from the Lacanian School, the Freudian left (Wilhelm Reich and Herbert Marcuse), and post-structuralists (Gilles Deleuze, Felix Guattari, and Foucault) to provide an outline for an analysis which would connect a theory of unconscious desire with a theory of societal development grounded in history. This discussion constitutes a very useful overview and critical evaluation of some difficult and challenging ideas, derived largely from continental theorists, which may be relatively unknown to most American sex researchers and practitioners.

The final section, Part IV, deals with challenges to “The Boundaries of Sexuality” shaped by the sexual tradition. Here Weeks examines the central role men and women participating in radical sexual politics of the 1970s and 1980s have had in changing such boundaries. He analyzes both the contribution of the gay and feminist movements in establishing a sexual identity based on choice rather than destiny in addition to the complex moral and political problems posed by the debate on pornography and the development of subcultures on the sexual fringe—those advocating sadomasochistic, public and/or inter-generational sex. The efforts of the sexually oppressed to legitimize and naturalize their own sexual needs has created a new type of sexual-political subject whose activities have, he maintains, gradually “evacuated meaning” from many of the sexologists’ categories. These new political subjects must now establish a political commitment which will bring sexual radicalism into play with feminism and socialism to effect a general social transformation. Under such a transformation, the flux of sexual desire would be allowed to flourish in the context of new social codes and new types of relationships. Weeks eschews invoking a particular theory on how such a transformation can be achieved, though like Marx, he holds that humans make their history and they can change it. “All we need,” he says, “is political commitment, imagination and vision.”

A major strength of Weeks’ analysis flows from his ability to draw on and

integrate seminal ideas from radical sociology; structuralist anthropology; semiotics; and psychoanalytic, feminist, and Marxist theory. Such ideas, excepting those of Freud, have typically not been included in discussions on theories of sexuality within mainstream American sexual science. This yields an analysis which, while it does not always succeed and certainly raises as many questions as it answers, points the way to one strategy for developing a theory of gender and sexuality grounded in history. A major weakness of the book is a failure to integrate effectively the biological level into this analysis; a critique of sociobiological ideas does not obviate the need to provide an extended interpretation of the biological factors which will support a social constructionist approach. Nevertheless, this is a fine book which should and will be of considerable interest to those concerned with sexuality in history, theories of sexuality, sexual and gender identity, or sexual politics and social change. **A, PR**

**Safe Sex in the Age of AIDS.** Prepared by The Institute for the Advanced Study of Human Sexuality. Secaucus, New Jersey: Citadel Press, 1986 (88 pp., \$3.95).

*Reviewed by George Marshall Worthington, MIPA, President, Worthington and Associates International.*

Every once in a long while, a book comes along that is near perfect in content, tone, format, and timeliness. Such a book is *Safe Sex in the Age of AIDS* by a group of professionals associated with The Institute for the Advanced Study of Human Sexuality in San Francisco. I wished it had been written sooner, but now that it is available, I hope *Safe Sex* will be widely distributed and read.

The book has a number of convenient features regarding its format and content. For starters, its size is small enough to fit discretely in a pocket or purse. It is 80 pages in length written in a non-nonsense and concise style. The content of the book—what is considered safe and unsafe in sexual conduct—consists of single page descriptions of each sexual practice together with a short paragraph detailing what is known about its associated degree of risk. This format made referencing topics especially easy.

In addition, the whole range of sexual behaviors described is further divided into three major categories: safe, possibly safe, and unsafe. This further strengthens the easy accessibility of the vital information in this book.

The book is one of the first to emphasize the risk of AIDS infection to both men and women, gay and straight. It contains discussion of the risk for transmission of HTLV-III through vaginal intercourse and cunnilingus. Since there are now well over 1,000 women in this country with AIDS and an alarming number of pediatric AIDS cases, such information is vitally needed. Damn the government for not having taken up this challenge—and, through neglect, perpetuating myth and prejudice and putting people at risk—and bless these authors for responding to this need!

The book is also highly recommended for its chapter directed to adolescents. The authentic, personable tone of this chapter clearly indicates a sensitivity to the challenges faced by teens, as well as long-term experience in counseling and working with them. Hopefully the Institute might consider publishing this chapter as a stand alone pamphlet for distribution to youth. I also hope that inclusion of this chapter on teens will rouse public health officials and others to recognize the serious danger that HTLV-III infection poses for young people in this country. A review of the general morbidity trends among youth should be enough to convince anyone that a significant number of adolescents are engaging in high risk behaviors (drug experimentation, unprotected intercourse, etc.) which are also known risk factors for transmission of HTLV-III and subsequent development of AIDS. Despite this, few organizations are planning to address the issue. Hopefully the importance given to the subject of youth and AIDS in *Safe Sex* will encourage people to address this issue.

Finally, the book is to be recommended for its emphasis on the positive aspects of safe sex instead of the negative aspects of unsafe sex, including its guidelines on what one can do to eroticize and enrich safe sex practices. This is sound pedagogy, but prior to this book, many successful educators writing about prevention and AIDS have failed to heed the lessons of their experience. Too many “don’ts” and not enough “dos.” Not that the “don’ts” have no place in AIDS prevention education; that goes without saying. But, particularly in the

area of people’s sexual lives, if you recommend that they limit their choices recommendations must be made to replace what has been lost; otherwise the message is ignored. This book scores a major success in my opinion on this point.

Other positive points of the book include:

1. The careful distinction between HTLV-III infection and AIDS: “People don’t catch AIDS”; a distinction many other books do not make, which then compounds the public’s misunderstanding about a complex medical condition;
2. Examples of conversations for negotiating safe sex with a new partner;
3. A short test to determine if you are a high-risk sexual partner;
4. A listing of products to help enrich the individual’s sex life while protecting them from the AIDS virus;
5. Handy little cut-out safe sex cards for both men and women.

Overall, this book is commended for its tone of encouragement and empowerment of the individual to make responsible sexual choices to limit the spread of HTLV-III infection. Without the medical control for AIDS, that is the only option open to us at this time.

Of course nothing is perfect, and there are some points which need improvement. The price of \$3.95 seems high for its size and is prohibitive for many people, such as teenagers or low-income people who also need this information. The cost of the book might discourage the widespread distribution of this book.

Second, though I admire the book for its candid approach, I did not think enough street language was used in the pages on sexual behaviors. More slang terms should be included to reach a wider audience, although the plain-English descriptions together with the most common slang terms is sufficient for most readers.

I was also concerned by the statement that the primary method of spreading the AIDS virus is through sexual contact. The federal Centers for Disease Control (CDC) has long been challenged for its concept of “hierarchical ranking” whereby gay intravenous (IV) drug users were only counted as gay in the national statistics, thus underestimating the serious threat of transmission through IV drug use and shared needles. In New York

City, the statistics are changing rapidly and drug use now accounts for the majority of cases. Other metropolitan areas can be expected to follow this trend. Therefore, I am concerned that these statements focusing on sexual transmission will date the book before too long, and it is too important a work to have that happen. In addition, I think this down plays the importance of recreational drug use as a co-factor in development of full blown AIDS once infection with HTLV-III has occurred.

Finally, many of the behaviors are discussed in terms of male-female hetero-

sexual relations. Perhaps it is an attempt to give the book the broadest appeal and based upon the knowledge that there is some excellent safe-sex literature available for gay people, and almost none for heterosexuals. I found it a little off-putting, and believe it would have been helpful to use more inclusive language.

In my opinion, *Safe Sex in the Age of Aids* is recommended reading for anyone who wants to know more about AIDS or anyone associated with the health field. Only with education can we begin to free society from this growing

economic and emotional burden, which is already exacting a heavy price in the form of pain, fear, and rekindled prejudice that could destroy decades of progress in civil liberties.

The book's non-prejudicial, non-nonsense concise and positive approach directed at all sexually active people is a triumph of collaborative writing. If this book gets into the hands of enough people—and I hope that this review will encourage people to go out and pick it up—it could be a real life saver. In the age of AIDS, it's the perfect gift for those you love. **ET, LT, A, P, PR**

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