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THE PAUSE

A Closer Look at Menopause and Female Sexuality

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What many women fear most when they think of menopause is an end to sexual desirability and pleasure. Because menopause is such a pejorative term in this culture and because it only refers to the date of a woman's last menstrual cycle, rather than the period of two to seven years of hormonal imbalance that accompanies the cessation of menstruation, I assert that it is important to rename the process. "The Pause" is a fitting name for menopause because it reflects the most positive aspects of the experience. It speaks of a break and a time to reflect. But as with pushing the pause button on the VCR machine, the expectation is to continue, not stop permanently. Indeed, most women — after they acquire a new equilibrium through this period — change the focus from children, spouse, and others toward their own self-fulfillment.

Since sexual attractiveness is so essential in defining a woman's self-worth in this culture, and since sexuality is so thoroughly entwined with reproduction, it is easy to see why many women fear losing sexual desirability once they can no longer have children. However, sexual desirability and sexual satisfaction have little to do with the ability to get pregnant. Sexual attraction is certainly a biological force fundamental to continuing the species. But just because women's work of bringing babies into the world has ended does not mean that the physical and emotional joys of sexuality must terminate as well. Because menopause signals the shutting down of reproductive abilities, it can have an impact on sexual functioning. From an evolutionary point of view, if a woman does not reproduce, she does not need to have intercourse. Consequently, sexual complaints are commonplace during menopause and afterward. The good news is that the difficulties encountered will not reduce satisfaction for about 80% of menopausal women. For the rest, safe and effective solutions are available.

Attitudinal Barriers

The sexual changes a woman experiences during The Pause may not be due to hormones. Psychological factors play a strong role in sexuality, and, for some women, menopause can be the long-awaited excuse to abandon sexual activity. Deciding to stop having sex is common among women who rarely found sexual relations pleasurable in the first place. This group can include women who were sexually abused in their youth, who were indoctrinated about the sinfulness of sexuality, or who have been involved with an inconsiderate or unknowledgeable lover. In addition, relationship problems can create major obstacles to sexual desire, especially when anger has built up over the years. When a woman feels that she has no power elsewhere in the relationship, she may find the only power she has is to say "no" in the bedroom.

Women who have been married for many years may feel they do not have the right to terminate sexual relations. A husband or male partner accustomed to an active sexual life may balk, blame, and induce guilt. But a good sexual relationship should provide sexual pleasure for both parties. If a woman has been dissatisfied, if the sexual relationship has offered no benefit, she may have no incentive to continue it merely for the pleasure of another. But there are actions women can take, if they choose, as I will describe later.

Single women have unique problems when it comes to sexuality. Women will outnumber men by approximately four to one in the later years; the odds of finding a male partner of one's own age are not exactly good. Certainly younger men are available, and many women are abandoning their preconceived notions that an older, more mature man is the only suitable partner. Others are expanding the parameters of their sexuality by exploring lesbian relationships. And many will remain uncoupled. Consequently, submerging sexual desires or replacing the loving hand of a partner with one's own hand may remain important alternatives, especially given the dangers of HIV/AIDS and other sexually transmitted diseases.

Finally, some women were raised to believe that sexual behavior should end at a certain age, that older women who are sexual appear degraded or comical. They may be embarrassed about sexual feelings and quash them in favor of perceived societal expectations.

Lubrication and Painful Intercourse

Blood flows into the pelvic region, and congestion causes secretion to seep through the semi-permeable membrane of the vaginal walls. As estrogen levels decline, blood flow to the vagina is reduced. The result is a change in lubrication. Besides a difference in the quality of lubrication, 40% to 60% of women experience an increase in the amount of time and stimulation required to become lubricated. When they do become lubricated, the amount produced is far smaller than in their younger years. For some women, this change in lubrication is the first harbinger of The Pause. Without sufficient lubrication, some women may doubt their level of sexual arousal. (Be aware that antihistamines and some decongestants can also dry out the mucous membranes; avoid them if you are experiencing vaginal dryness.)

Not having enough lubrication or having lubrication that is insufficiently viscous can make intercourse painful. I remember that in the very early stages of menopause, before I knew what was happening, my vagina would remain dry regardless of the nature or duration of intercourse. For a time, I found myself avoiding sexual intercourse. It was just too uncomfortable. Then I started to use Astroglide, a lubricant available in most pharmacies that is specifically designed for sexual use. *[See box on page 4 for more information about lubricants.]* That made a big difference. But after a couple of years, intercourse was painful or it burned no matter how much lubrication we used. I did not know it then, but the vagina is rich with estrogen receptors. When deprived of estrogen, the lining gets thinner over time and may lose elasticity. Thinner vaginal tissues mean less cushion against the friction of the thrusting penis. The result can be a mild burning sensation during lovemaking and sometimes for hours or even days afterward. One may also feel a greater need to urinate after intercourse.

This pain or burning during intercourse can begin long before a gynecologist is able to detect changes in vaginal tissues. Many women question themselves or their partners or look for other psychological causes when sexual intercourse becomes painful and a physician can find no physical cause for it. Why the change in estrogen creates pain with intercourse for some women, but not for others, is unknown. But this does not mean one has to stop having sexual intercourse. It does mean some women will probably have to make some adjustments if intercourse is to continue to be enjoyable.

Hormones

While a lubricant will solve discomfort due to lack of lubrication, it will not reduce pain caused by thinned vaginal tissue and decreased elasticity. Estrogen, however, addresses these problems. Estrogen keeps the vaginal lining plump, lubricated, and pain-free. If the only problem experienced during menopause is discomfort while having sexual intercourse, one can insert estrogen cream directly into the vagina a few times a week. Although some women notice a difference after their first application, others may have to use the estrogen cream for a month before they respond.

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In sufficiently low doses, Estrace cream (estradiol) inserted vaginally can even be used safely by women who have had an estrogen dependent cancer. "Every woman is different, so we give women very low doses of estradiol cream vaginally, and then check the estradiol levels in their blood," reports Dr. Lila Nachtigall, director of the Women's Wellness Division, Department of Obstetrics and Gynecology, at New York University. A one- or two-percent testosterone cream that can be made up specially by a pharmacist can have the same effect on the vaginal tissues as estrogen cream. The only drawback of estrogen and testosterone creams is that they can be messy. It is also important to note that hormone creams are not designed to be lubricants.

Non-hormonal treatment is also available. For instance, the herb chasteberry can revitalize vaginal tissue and diminish the pain of intercourse, but it generally takes a few months to experience positive results.

Sexual Touch and Sensitivity

Some women respond to The Pause with changes in skin sensitivity, which can affect sexuality. They may find that they like a harder stroking or a gentler touch than in the past. Areas once aroused when touched may now not respond or may actually feel irritated. This is particularly true of the breasts, which frequently become far more painful both at mid-cycle and during the last week before menstruation begins. To decrease breast pain, take 400 to 600 international units of vitamin E each day. It might be best to take a low dose during most of the month and then increase the dose at the point in the menstrual cycle when the breasts feel most tender.

Some women notice lessened sensation upon deep thrusting during sexual intercourse. With decreased estrogen, the pressure sensors in the cervix may become less responsive. Some women experience this as a great loss in sexual pleasure. However, estrogen supplementation will increase responsiveness. In fact, estrogen appears to have a positive impact on all aspects of sexual functioning during and after The Pause.

Orgasm

With decreased hormones many women find that their orgasmic responses change. Changes in orgasm can be the result of reduced estrogen, which limits pelvic blood flow, or the result of insufficient testosterone. While some women find that their orgasms become more intense over the years, more common changes include taking longer to reach orgasm, reaching orgasm less frequently, or having less intense orgasms.

For most women, however, these changes in orgasm are not significant and do not necessarily diminish sexual enjoyment. In fact, while women may experience less intense orgasms, they often describe them as gentler and sexier.

Occasionally, women experience painful contractions with orgasm, almost like a muscle spasm. "A lack of estrogen can cause painful contractions during orgasm," according to Dr. William Masters of the Masters and Johnson Clinic in St. Louis. "These contractions are quite real, and there is nothing psychological about them. But if you take estrogen in some form, you can eliminate them."

Contraception

We all know about menopausal babies. And while few women get pregnant during The Pause, it certainly remains a possibility. Women who want to ensure protection from pregnancy should continue to use contraception until one year after their last period. For women in non-monogamous relationships, condoms should be used even after that — HIV and other sexually communicated diseases respect no age limits.

Post-menopause

Symptoms like hot flashes, fatigue, and sleep disturbances tend to diminish in intensity and then finally disappear within a year or two after the last menstrual cycle. If a woman is not manufacturing sufficient estrogen in her fat cells, changes occurring in her sexual organs will continue to progress until she seeks to remedy it.

Without sufficient estrogen during the post-menopausal years, the vagina becomes less elastic and shrinks. This means that, during arousal, the most interior end of the vagina no longer balloons out as far as it did in the past. The vaginal lining will change to an almost paper-thin consistency. The result is that unless the vagina is kept stretched, intercourse will be painful if one should stop having sexual intercourse for an extended period and then try to start again. This situation can be ameliorated, however, within about six weeks if an estrogen cream or hormone replacement therapy is used in addition to stretching the vaginal walls with a dilator or dildo.

To stretch the vaginal walls, begin with something narrow, like a Q-Tip or your pinky. Lie on your back with your knees raised; lubricate the vagina and the object to be inserted, then bear down — as if you were trying to push something out of the vagina — as you slowly insert the object. This bearing down actually relaxes the vaginal opening and makes insertion easier. Leave the object in for fifteen minutes. Then push the object in and out of the vagina to help stretch the anterior wall. Once this is comfortable, use objects of increasing width and length. Dildoes come in many different sizes and can be purchased by mail.

Masturbation

For women who do not have partners or are not sexually active with a partner, it may be in the best interest of health and psyche to continue masturbating. Many women have been brought up to feel guilty and abnormal about masturbating. However, a New Jersey study now shows that regular masturbation after menopause actually keeps the vagina healthy. Masturbation helps maintain the lubrication process, and masturbation with something inside the vagina like a dildo can keep the vaginal walls stretched.

In addition, many women need the physical release masturbation affords. It makes them feel better and less tense. Masturbation can provide its own kind of sexual pleasure. Consequently, it is often enjoyed in addition to partnered sexual activity.

Decreased Sexual Desire

Many women fear that menopause means loss of sexual desire, as well as sexual desirability. And the truth is that

at least 35% of women will experience a reduction in sexual desire during The Pause and afterward. In recent research, Dr. Norma McCoy, a psychologist specializing in hormones and sexuality at San Francisco State University, found that "the biggest decline in sexual intercourse took place during the one-to-two-year period before a woman's last menstrual cycle. In addition, over 50% of the sixteen women we studied showed a decrease in sexual thoughts and fantasies during the years around menopause." The loss of sexual desire can be gradual or sudden. Sometimes it occurs early in the process of menopause, sometimes not until five or more years after the last menstrual cycle. For some women the effect is transient, for others permanent.

Desire often abates when insomnia, hot flashes, and other symptoms of The Pause interfere with energy and sense of well-being. Not feeling well is a major sexual inhibitor. So is pain. Women who are experiencing pain with intercourse caused by a lack of lubrication or a thinning of the vaginal lining may find themselves avoiding sexual activity. Sexual desire is likely to return, however, once the discomforts of the transition have passed or some form of treatment (estrogen, homeopathy, acupuncture, herbs, or lubricants) have stopped the symptoms.

A lack of testosterone, particularly bioavailable testosterone, can also reduce sexual desire. Ovaries and adrenal glands each produce approximately half of a woman's testosterone supply. "We don't know why, but for approximately 50% of women, testosterone stops being produced in the ovaries at about the time of menopause," reports Dr. Barbara Sherwin of McGill University. "The rest maintain normal ovarian production for some period of time."

There is no absolute level of testosterone necessary to feel sexual desire; as with estrogen, each woman has a different set-point. But if testosterone falls below an individual's base level, she is apt to experience a decline or absence of sexual desire, a decrease in clitoral sensitivity, and increased difficulty in attaining orgasm either through masturbation or with a partner. These testosterone-related changes apparently occur in about 10% to 20% of women who experience a lack of desire early in The Pause, but they account for the majority of cases when symptoms appear a number of years past the last menstrual cycle. Women who have had their ovaries surgically removed often experience a precipitous drop in testosterone — as well as sexual desire — virtually overnight.

Progesterone competes with testosterone for receptor sites. This means that even if a woman has sufficient testosterone, but has too much progesterone, she may experience a lack of desire because progesterone is filling up the receptors. These women may experience a lack of desire in the second half of their cycle.

Treating Lack of Sexual Desire

"Some research shows that Premarin, the most popular estrogen pill, can decrease levels of bioavailable testosterone in some women," says Dr. Norma McCoy. "If you are feeling a lack of desire and are on Premarin, you might want to switch to Estrace or the patch." The patch is a product that adheres to the skin and releases hormones into the body.

If a woman is taking estrogen and her symptoms disappear, she may still feel a lack of desire and need additional testosterone. The safety of prescribing additional testosterone, however, is currently a controversial subject. There is fairly strong agreement that testosterone, in high doses, can produce facial hair, lowered voice, weight gain, and acne, and it can adversely affect blood lipid levels and the liver. The question is: how potentially negative are small doses of testosterone? Dr. John Arpels of San Francisco, a gynecologist and founding member of The North American Menopause Society says, "I generally prescribe a two-milligram tablet of testosterone two to seven times a week when appropriate. As long as the dose is below seventy-five milligrams per month, only 5% or fewer of my patients experience weight gain, hair growth, or acne."

A greater concern is the effect of oral testosterone on cholesterol levels. One product on the market, Estratest, combines estrogen and testosterone in one tablet. Dr. Morris Notelovitz, president and director of the Women's Medical and Diagnostic Center and Climacteric Clinic in Gainesville, Florida, has been studying Estratest. "We compared the effects of Estratest and Estratab, which both

LUBRICANTS

- Good water soluble lubricants include: **Astroglide**, **K-Y Jelly**, and **Calendula** (marigold) in cream, gel, or ointment. Water-based lubricants are preferable because oil-based products are not secreted from the vagina as easily and can cause vaginal infections. But some women find water-based lubricants not viscous enough to protect them.

- Oil-based lubricants can include: **Vaseline**, **coconut oil**, **oil from Vitamin E capsules**. Please remember not to use petroleum-based products with latex condoms because they weaken the latex.

- Vaginal moisturizers: **Lubrin**, inserted a half hour before making love, **Replens** and **Vitamin E softgels/ suppositories** inserted vaginally once a day to twice a month as needed can keep vaginal tissues moist.

- **Zinc** (15 mg/day) has a positive effect on vaginal secretions. Foods that are rich in zinc include nuts, seafood, meats, wheat germ, and oats.

contain esterified estrogen, but Estratest also includes testosterone. We found that the women on the combination treatment showed greater improvement in symptoms like depression, anxiety, and libido, when compared to women taking Estratab, who also showed improvement, but not to the same extent. Secondly, the patients on combination treatment showed greater improvement in their bone density when compared with Estratab by itself. The only negative thing about Estratest is that it did decrease HDL cholesterol (good cholesterol), although it remained within normative range. On the other hand, Estratest significantly decreased triglycerides, which in some women is a particular problem. So the bottom line is that treatment must be tailored to the individual. Estratest has an important role in treating menopausal women, but not all menopausal women."

The effects of oral testosterone on masculinization or cholesterol are only one part of the issue, according to Dr. Norma McCoy. "The real issue concerns the negative effects of synthetic hormones on liver proteins. We simply do not know enough about the long-term adverse effects of low doses of these synthetic hormones when taken orally. In addition, synthetic hormones, like Premarin when taken orally, increase the liver's production of binding proteins, which then selectively bind testosterone. When the testosterone is bound, it is not bioavailable, and it cannot enhance sexual interest."

Testosterone can also be taken in some non-oral routes. A one- or two-percent testosterone cream can be made up by a pharmacist and rubbed on the inner labia every few days. Testosterone pellets that act for six months can be inserted under the skin, and Depo-Testadiol or Depo-Testosterone can be given by injection once every four to six weeks. However testosterone in pellets inserted under the skin and testosterone injections are generally used only with women whose ovaries have been surgically removed. Research shows that these non-oral routes have no negative impact on the liver or blood lipid levels. According to Dr. Victoria Maclin, a reproductive endocrinologist at Rush Medical College in Chicago and one of the few physicians using testosterone pellets in this country, "The women I have treated complain of either a diminished libido or a total lack of sexual desire. They also feel more lethargic and have less zest for life. Adding testosterone to their hormonal replacement, if their testosterone levels are low, restores their libido and improves their sense of well-being. And those changes have not been accompanied by increased hair growth, weight gain, or acne."

Regardless of the form in which one takes testosterone, the treatment must be carefully monitored by a physician. Not all women, however, are concerned about reactivating their level of sexual interest. With declining sexual need, they find their energy turning in other directions.

Increased Sexual Desire

According to a Danish study, 9% of women report increased sexual desire at some point during or after The Pause. A variety of factors can account for such an increase. With no more fears of pregnancy, menopause can open whole new areas of sexual freedom for some women. A new partner can revitalize a woman's sense of her own sexuality, while for women in long-term relationships, no longer having the children at home can mean a second honeymoon.

There are also hormonal reasons for increased desire during menopause. Dr. McCoy has examined sexuality across the life-span and made some interesting discoveries. "We found a peak in sexual interest in women in their early forties. Kinsey and his colleagues observed the same thing, but he ascribed it to culture, believing that it took that long for women to overcome the sexual inhibitions instilled in youth. But it appears that hormonal changes may be the more likely reason."

Just as you turn up the volume when you cannot hear the television, when estrogen levels decrease, the body tries to stimulate more estrogen by turning up the follicle stimulating hormone (FSH) and luteinizing hormone (LH). In addition to stimulating the ovaries to produce estrogen, the increased LH and FSH stimulate special cells in ovarian stromal tissue to make testosterone. Some women are more efficient than others at producing testosterone this way. It may be that these women are the ones most likely to experience increased sexual desire. If you should be in the lucky minority — with both a loving partner and an increased level of desire -- enjoy your good fortune.

Conclusion

It appears that during The Pause sex is good both for relationships and health. Dr. Winnifred Cutler, co-founder of the Women's Wellness Program at the Hospital of the University of Pennsylvania, observed that women who had intercourse regularly, once a week or more, had twice as much estrogen circulating in their blood as women who were either not sexually active or only active sporadically. Women with more active sex lives showed fewer negative changes in the mucousal lining of the vagina and tended to have less severe hot flashes.

A study in Denmark has shown that only 18% of women who had sexual intercourse more than twice weekly at forty-five years of age were likely to notice a decrease in sexual desire after menopause. In contrast, 47% who had intercourse less than twice weekly noticed a decrease. These findings could be interpreted as "use it or lose it," or that higher levels of circulating hormones are associated with more frequent sexual activity. Either way, if sex is personally important, there are options available to treat interfering symptoms or depressed desire. A high priority on masturbation or sexual activity with a partner can help promote an active sexual life for a long, long time.

This article is adapted for the SIECUS Report *from a chapter in Dr. Barbach's new book,* The Pause: Positive Approaches to Menopause *(New York: Dutton, 1993). Dr. Barbach is an internationally known lecturer and best-selling author of numerous books on sexuality, including* For Yourself *and* For Each Other. *She has also completed a 90-minute video entitled* Sex After 50 *(available through The Institute for Health and Aging, 1/800-866-1000).*

BOOKS ON MENOPAUSE

In 1992, the topic of menopause burst out of the closet and took its place in the media spotlight along with sexual abuse and co-dependency. *Neusweek* devoted a cover to menopause with an unforgettable image — a woman's profile made of tree branches, with only a few remaining leaves, an image suggesting the onset of a cold, hard winter. The branches appear eerily as the wrinkles in the face. Another *Neusweek* cover shows a distraught cartoon face of a woman with a thought bubble that reads, "Oh, God, I'm really turning fifty!"

Among the books on menopause published in 1992, Gail Sheehy (of *Passages* fame) hit and stayed on the best-seller list for 44 weeks with her *Menopause, The Silent Passage*. A quick read, Sheehy's book is 150 pages of light, *entre-nous* style text. Ingenious marketing of the book resulted in its almost singlehandedly making menopause a trendy topic. Not many months later, Germaine Greer (best known for her 1970 book, *The Female Eunuch*) published *The Change: Women, Aging, and Menopause*. It is hefty and polemical, but proactive in interesting ways. It has not sold nearly as well as Sheehy's, which is a shame. As flawed and infuriating as it is in places, Greer's book is a true contribution. She has a knack for making her readers think.

The questions of biology and hormone replacement therapy are controversies that merit a few words. Sheehy unfortunately relies too heavily on interviews with doctors (not all of them experts in the field) in discussing these matters. For example, she quotes her own gynecologist extensively. "We hope provera [a progestin, usually taken half the month] reduces the risk [of uterine cancer], but we don't know for certain" (p. 20). In fact, we do know from several well-designed studies that women taking estrogen who also take Provera twelve days a month, have no increased risk of uterine cancer. Some studies even find that women on this particular hormone replacement therapy regimen have a lower incidence of uterine cancer than women taking no hormones at all. Greer thoroughly reviews the medical literature and has a good grasp of the science. However, her errors are frustrating. She writes, "the present state of knowledge is insufficient to show whether administration of replacement estrogens...is sufficient to prevent...bone loss....there are no estrogen receptors in bone" (p.130). In fact, we have known for six years that there are estrogen receptors in bone, and that estrogen replacement prevents bone loss. When famous authors make such errors, it is difficult for readers to make informed decisions.

Sheehy's coverage of sex and menopause reflects both her strengths and weaknesses. *Menopause, The Silent Passage* is fun to read. "Sand slid into bed....She was thinking, I'll be a menopause centerfold. I have this glistening body, right? At the peak of a hot flash — you want a hot woman? This is a hot woman. Her new husband maneuvered her into position. And then, it hurt." However, the quality of the information is not acceptable. For instance, when Sheehy wants to report on the percentage of women who experience a decline in sexual desire after menopause, she relies on an interview with senior physiologist, Dr. Ramey, of Georgetown University, who estimates the percentage to be about 30. "The figures are unreliable because doctors don't ask women about their sex drives," adds Ramey. While this figure of 30% happens to be accurate, there is certainly no shortage of research data, which Sheehy could easily have accessed.

Compared to Sheehy's *Reader's Digest* style of book, Greer's work is more along the lines of the *Partisan Review*. In fact, *The Change: Women, Aging, and Menopause* includes extensive quotations about sexuality and women, from Shakespeare, to Byron, Lady Mary Wortley Montague, Colette, Emily Dickenson, plus many menopause experts whose studies she has analyzed and critiques cogently. The breadth of her scholarship is exceptional, which is why her radical tirades against men, doctors, and the pharmaceutical companies are so exasperating. For instance, she writes, "When we give a male hormone to a married woman who has lost her interest in sex, we are consciously tailoring her sexuality to fit her husband's; the whole business smacks of women's willingness to try anything for a quiet life" (p. 177). How can such a feminist as Germaine Greer not give women more credit than that? Most women I know who have lost their sexual zest are usually devastated and want to recover it for themselves. On the other hand, Greer is right to warn against the tendency to oversell sex. She writes to reassure sexually inactive women who will become "neither mad nor ill as a result of a failure to exercise genitals regularly or at all" (p. 8).

A few words about other books

Lila Nachtigall, *The Complete Guide to Reversing the Effects of Menopause Using Hormone Replacement Therapy* (Harper Collins, 1991) is an excellent, comprehensive, current guide by one of the most widely respected doctors in the menopause field.

Wulf Utian and Ruth Jacobowitz, *Managing Your Menopause* (Simon and Schuster, 1990) is a well-balanced presentation which is up-to-date and correct.

Susan Fiemholtz Trien, *The Menopause Handbook* (Ballantine Books, 1986) is a good try, but the discussion of hormone replacement therapy and heart disease is out of date and misleading. The chapter about sexuality is spotty.

Ruth Jacobowitz, *150 Most-Asked Questions about Menopause* (Hearst Books, 1993). This book is unnecessarily cautious about hormone replacement therapy and heart disease. The information about sexuality is derived largely from the author's observations of her own menopause discussion group and a 1991 Gallup poll, with no literature review. She often paraphrases without citing references. Her tone is balanced and sensitive.

Susan Perry and Katherine O'Hanlon, *Natural Menopause* (Addison-Wesley, 1992) is a general book that emphasizes non-hormonal approaches to treating menopause.

Reviewed by Lorna Sarrel, MSW, Co-Director, Human Sexuality Program, Yale University, and Vice President of the SIECUS Board of Directors.

WHAT DOCTORS AND OTHERS NEED TO KNOW

Six Facts on Human Sexuality and Aging

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Most of us find that our definition of old age changes as we mature. To a child, anyone over forty seems ancient. Sixty-five and older is the common governmental definition of a senior citizen, and it is the definition that I will follow here, although the author (who is in his late 70s) long ago began to find it hard to accept. There is, of course, no specific turning point, but rather a series of gradual physical and emotional changes, some in response to societal rules about retirement and entitlement to particular benefits.

Demographically, the elderly are a rapidly growing segment of the population. In 1900, there were about three million older Americans; by the year 2000, there will be close to 31 million older Americans. Because of high male mortality rates, older women outnumber men 1.5 to 1, and since most are paired off, single women outnumber single men by about 4 to 1. By definition, the elderly were born in the pre-World War I era. Most were thoroughly indoctrinated in the restrictive attitudes toward sex that characterized these times.

In my opinion, the care of the elderly could be significantly improved if doctors and other health workers would remember the following six, simple facts.

Fact #1: All Older People Are Sexual

Older people are not all sexually active, as is also true of the young, but they all have sexual beliefs, values, memories, and feelings. To deny this sexuality is to exclude a significant part of the lives of older people. In recent decades, this simple truth has been repeatedly stated by almost every authority who has written about sexuality, but somehow the myth persists that the elderly have lost all competence, desire, and interest in sexuality, and that those who remain sexual, particularly if sexually active, are regarded as abnormal and, by some, even perverted. This myth would seem to have at least three components. First, it is a carryover of the Victorian belief that sex is dangerous and evil, though necessary for reproduction, and that sex for recreational purposes is improper and disgusting. Second is what Mary S. Calderone, SIECUS co-founder, has called a tendency for society to castrate its dependent members: to deny the sexuality of the disabled, of prisoners, and of the elderly. This perhaps reflects a subconscious desire to dehumanize those whom we believe to be less fortunate than ourselves in order to assuage our guilt feelings. Third, Freud and many others have pointed out that most of us have a hard time thinking of our parents as being sexually active, and we tend to identify all older people with our parents and grandparents.

For whatever reason, it is unfortunate that young people so often deny the sexuality of those who are older. It is even more tragic when older people themselves believe the myth and then are tortured by guilt when they experience normal, healthy sexual feelings. Doctors and other health workers need to identify and alleviate such feelings of guilt.

How many people are sexually active? It is generally agreed upon by experts that the proportion of both males and females who are sexually active declines, decade by decade, ranging according to one study from 98% of married men in their 50s to 50% for unmarried women aged 70 and over.[1] At each decade, there are also some people who are inactive. It is important to accept abstinence as a valid lifestyle as well — at any age — as long as it is freely chosen.

Fact #2: Many Older People Have a Need for a Good Sexual Relationship

To a varying extent, the elderly experience and must adapt to gradual physical and mental changes. They may find themselves no longer easily able to do the enjoyable things they used to do; their future may seem fearful; retirement and an "empty nest" may leave many with reduced incomes and no clear goals in life; friends and/or a lifetime partner may move away, become ill, or die; and the threat of loneliness may be a major concern. Fortunately, many older people are not infirm, frustrated, fearful, bored, or lonely; nonetheless, some of these elements may be affecting their lives. An excellent antidote for all this is the warmth, intimacy, and security of a good sexual relationship.

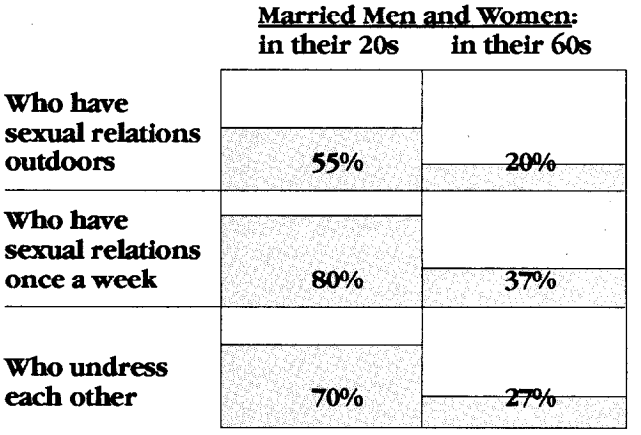
Fact #3: Sexual Physiology Changes with Age

In general, physiological changes are gradual and are easily compensated for, if one knows how. But when they sneak up on an unsuspecting, unknowledgeable individual, they can be disastrous. Health workers need to be familiar with these changes and with how they can help patients adapt to them.

Older men commonly find that their erections are less frequent, take longer to achieve, are less firm, and are more easily lost. Ejaculation takes longer, is less forceful, and produces a smaller amount of semen. The refractory period (the interval between ejaculation and another erection) is often prolonged to many hours or even days. The slowing down of the sexual response cycle can be compensated for simply by taking more time, a step usually gratifying to one's partner, especially if he or she is elderly. But in our society many men grow up believing that their

Research Note

Andrew Greeley, priest, author, and sociologist at the University of Chicago analyzed national-poll data of 6,000 respondents and found that sexual activity is plentiful, even after the age of 60. He reported in 1992 that 37 percent of married people over 60 have sexual relations at least once a week — and one in six respondents had sexual relations more often. Greeley concluded that sexually active married men are happier with their spouses at 60 than 20-year-old single males who have many sexual partners. His report, "Sex After Sixty: A Report," based on surveys by the Gallup Organization and the National Opinion Research Center included the following results:



manliness, their power, and their competence depend on their ability to "get it up, keep it up, and get it off." For such an individual, slowing of the cycle may induce performance anxiety, complete impotence, and panic. Good counseling about the many advantages of a leisurely approach can make a world of difference for such an individual.

The prolonged refractory period may prevent a man from having sexual relations as often as he formerly did, but only if he requires that the sexual act build up to his ejaculation. If he can learn that good, soul-satisfying sexual activity is possible without male ejaculation, then he can participate as often as he and his partner wish. Finally, men (and sometimes their partners) need to learn that wonderful sex is possible without an erect penis. Tongues, fingers, vibrators, and many other gadgets can make wonderful stimulators and can alleviate performance anxiety.

Some women find the arrival of menopause disturbing; others feel liberated. If one has grown up in a society that believes that the major role for women is bearing children, then the loss of that ability may make one feel no longer a "real woman." The most common sexual problem of older women, however, is vaginal dryness, which can make sexual intercourse painful, particularly if her partner is wearing an unlubricated condom. The obvious solution is to use one of the many water-soluble lubricants available in drug stores. Saliva is a fairly good lubricant and it does have four advantages over commercial products: 1) it is readily available wherever one may be; 2) it is free; 3) it is at the right temperature; and 4) its application is more intimate than something from a tube.

An alternative approach attacks the root of the problem. Vaginal drying results from a decrease in estrogen and can be reversed with estrogen replacement which also prevents other consequences of menopause like hot flashes and loss of calcium from the skeleton. But estrogen administration may increase the risk of uterine cancer; therefore, each woman and her doctor will need to balance out the risks and benefits in her particular situation.

Aging inevitably changes physical appearance and, in our youth-oriented culture, this can have a profound impact on sexuality. It is not easy to reverse the influence of many decades of advertisements for cosmetics and clothes, but doctors can at least try to avoid adding to the problem. Many medical procedures — particularly mastectomy, amputations, chemotherapy, and ostomies — have a profound impact on body image. It is of utmost importance to discuss this impact before surgery and to be fully aware of the patient's need to readjust during the post-operative period. When possible, involvement of the patient's sexual partner in these discussions can be very helpful.

Fact #4: Social Attitudes Are Often Frustrating

As indicated above, society tends to deny the sexuality of the aged, and in so doing creates complications in their already difficult lives. Laws and customs restrict the sexual behavior of older people in many ways. This is particularly true for women, since they have traditionally enjoyed less freedom and because, demographically, there are fewer potential partners for heterosexual, single women, and many of the few men that are available are pursuing women half their age.

Some professionals have suggested that women explore sexual behaviors with other women. However, we know that sexual orientation, although potentially fluid throughout a life-span, is more complicated than the suggestion implies. While some women discover lesbian sexuality at an older age, it is rarely the result of a decrease in the availability of male partners. When doctors see an older woman as a patient, they can, at least, inquire into sexual satisfaction. If sexual frustration is expressed, they can be understanding. Some women can be encouraged to try masturbating, and some will find a vibrator a delightful way to achieve orgasm.

Older people are living in a variety of retirement communities and nursing homes. This brings potential sexual partners together, but tends to exaggerate the gender imbalance. In retirement homes, single women often outnumber single men, eight or ten to one. Furthermore, rules, customs, and lack of privacy severely inhibit the establishment of intimate relationships at these sites.

Administrators of such homes are often blamed for this phenomenon. Some are, indeed, unsympathetic, but we must also consider the attitudes of the trustees, the neighbors, and the legislators who oversee the operation, and particularly the attitudes of the family members. If two residents establish a sexual relationship, it is often followed by a son or daughter pounding the administrator's desk and angrily shouting, "That's not what I put Mom (Dad) here for!"

Fact #5: Use It Or Lose It
Sexual activity is not a commodity that can be stored and saved for a rainy day. Rather, it is a physiologic function that tends to deteriorate if not exercised, and it is particularly fragile in the elderly. If interrupted, it may be difficult (though not impossible) to reinvigorate. Doctors should work with the patient and partner on reestablishing the ability if desired.

Fact #6: Older Folks Do It Better
This may seem like an arrogant statement to some, but much depends on what is meant by "better." If the basis is how hard the penis is, how moist the vagina, how many strokes per minute, then the young will win out, but if the measure is satisfaction achieved, the elderly can enjoy several advantages. First, they have usually had considerable experience, not necessarily with many different partners. One can become very experienced with a single partner. Second, they often have more time, and a good sexual relationship takes a lot of time. The young are often pressured by studies, jobs, hobbies, etc., and squeeze their sexual activities into a very full schedule. Older folks can be more leisurely and relaxed. Finally, attitudes often improve with aging. The young are frequently insecure, playing game, and acting out traditional roles because they have not explored other options. Some older folks have mellowed and learned to roll with the punches. They no longer need to prove themselves and can settle down to relating with their partner and meeting his or her needs. Obviously one does not have to be old to gain experience, to set aside time, or to develop sound attitudes. Perhaps the next generation of Americans will discover how to learn these simple things without wasting thirty or forty years of their lives playing silly games. One hopes so.

Conclusion
In summary, older people are sexual, often urgently need sexual contact, and yet encounter many obstacles to enjoying its pleasures, some medical, most societal. Doctors and other healthcare providers need to be aware of these problems and need to help those who are aging cope with them.

Dr. Richard J. Cross originally wrote this article for the SIECUS Report in 1988.

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GAY AND LESBIAN AGING

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Little is known about mid-life and older adults who are gay men or lesbians. The field of gerontology has only recently begun to acknowledge that older adults are sexual beings, and the prevailing assumption is that sexual means heterosexual. The growing research in gay and lesbian studies suffers from the ageist tendency to be interested only in issues that affect younger or middle-aged gay or lesbian adults. Thus, information about aging issues as they relate to older gay men and lesbian women ranges from scarce to non-existent.

Gerontologists have come to believe that there are at least two groups of older adults who are commonly classified as aged or elderly. Neurgarten labels these, "young-old" and "old-old."[1] The "young-old" adult is aged 55-60, may be retired or planning to retire, and may have health problems that are beginning to affect his or her daily activities. The "young-old" adult still has an income, is active and not dependent on others for help. The "old-old" adult is 75-85 years old and may be economically and physically in need of help. Frequently, the "old-old" adult has multiple health problems, reduced or severely limited income and savings, and has suffered many losses (friends, family, job, health, home, etc.). It is rare to find information on the classification of "old-old" adults who are also gay men and lesbians. It is in fact more likely to find material written about aging gay men and lesbians referring to adults 30-40 years old.

Generalized Patterns in Older Gay Men and Lesbians

One reason that so little is known about gay and lesbian older adults is that they are hidden, particularly when over the age of 60. "Coming out" or acknowledging one's sexual orientation has historically not been viewed or experienced as a positive event. For the most part, our homophobic society deems gay men and lesbians as immoral and, in some states, their sexual practices illegal. Nonetheless, while there are a variety of patterns in the aging of gay men and lesbians, some emerge as more common than others.

For instance, many very old gay men and lesbians have never defined themselves as homosexual. Many older women lived their lives somewhat safely in "coupled" relationships with another woman. While there may have been whispers and suspicions about these women, it was fairly acceptable for women to be roommates and share housing for economic and safety reasons. Gay men, on the other hand, tended to find their safety in marriages to women and to have sexual relationships with men outside the marriage. In this way, many homosexual relationships were hidden. Non-married men were understood by friends and family to be "confirmed bachelors."

The strong moral, social, and legal injunctions against homosexuality have weighed heavily on this population of gay men and lesbians. It is rare, though not impossible, to find a very old adult who "comes out" in the last stages of life. A poignant example can be found in Ellen,* a frail eighty-seven-year-old woman who entered a long-term care facility after the death of her roommate, who had also been her caretaker. Ellen overheard two young aides from the facility discussing lesbianism. After several months had passed, the older woman gathered the courage to ask one of the aides more about the meaning of the word "lesbian." Again, several weeks passed before she was able to confide in the aide about her own relationship with her roommate that may have been a lesbian relationship. While Ellen appeared to gain some relief from this discussion and her ability to explore her own grief over the loss of her roommate in a new context, she later became terribly agitated and anxious. She was extremely fearful that her story would be told to others in the facility without her consent. She died one month later.

Problems Studying Older Gay Men and Lesbians

It is difficult — if not impossible — to expect that researchers will ever learn very much about the "old-old" adults who are lesbians or gay males. The older adult who is willing to discuss his or her sexuality is an exceptional case and may not offer insight into the closeted elderly, who comprise the vast majority of this population.

Several methodological problems exist that create obstacles to understanding gay and lesbian aging. Most studies focus only on those gay and lesbian adults who are members of political or social organizations or who are known to other gay and lesbian adults. A prominent sexuality researcher, J. Harry states, "Our studies of homosexuals are largely studies of active gays, those for whom sexual orientation constitutes a lifestyle."[2] Most of the early studies in this area focused on small samples — usually only 10-20 adults.[3] Respondents were selected through community networks of older gay and lesbian people. Studies were frequently confined to one particular group such as professionals or gay and lesbian adults living in the same community. Location has also been limited to New York, San Francisco or Los Angeles, reflecting an urban bias in the understanding of this population. Additionally, older gay men and lesbians from working-class backgrounds are under-represented, as are adults representing ethnic and racial diversity. It is notable, however, that new research to study African-American aging gay males and to study gay and lesbian adults in rural areas is being launched.[4] Early studies in this area initially grouped gay men and lesbians together as

one study cohort, assuming that homosexuality made these men and women more similar than gender made them unique. In a recent study to examine gender (as well as age) differences, Quam and Whitford found significant gender differences in living situation, housing, friendship, community participation, and interest in gay and lesbian organizations and housing.[5] It is clear that critical information is lost if gender differences in the gay and lesbian population are not acknowledged.

Finally, there is the problem of self-reporting. No viable method has been discovered to study this population other than direct questioning. Depending on who is asking the question (age, gender, race, sexual orientation of the interviewer) and how the questions are administered (survey by writing, telephone interviews, etc.), there may be great variability in data. Fear of being "outed" or exposing information that has been shared only with a partner or intimate is often extremely threatening to aging gay men and lesbians. Contribution to research knowledge is often not perceived as compelling enough to compromise one's privacy.

Importantly, researchers have learned that gay and lesbian adults have some of the same concerns about aging as heterosexual older adults. For instance, most older Americans are concerned with income, unexpected debilitating illness, economic hardship, fear of losing friends and family, moving to a new location, difficulties protecting oneself, autonomy, and provision of health care. For the gay and lesbian older adult, however, there is an added concern directly related to sexuality. For example:

- A 55-year-old lesbian who is diagnosed with breast cancer may be afraid to tell her physician about her sexual orientation. Will he treat her differently because she is a lesbian? Will her partner be included in decision-making about her health?

- A 63-year-old lesbian came out to her adult daughter several years ago, but her daughter has asked that the grandchildren not be told. Will this lesbian grandmother be able to count on support from family members who are not aware of her life and sexuality?

- Two gay men in their seventies have planned well for old age. However, they worry about how they will be treated if one or both of them requires long-term care. They have lived together for thirty years. Will that relationship be recognized by social service providers? Will the law uphold the right of one to make decisions for the other as if they were legally recognized spouses?

Current Findings about Older Gay Men and Lesbians

Although the current cohort of very old gay and lesbian adults are probably not interested in being recognized as different from other older adults, the younger cohorts (50-65 year olds) seem to have a strong interest in services and programs which pay attention to their unique needs. Quam and Whitford studied gay and lesbian adults in their study of 80 self-identified lesbians and gay men over the age of 50 living in a midwestern metropolitan area. The authors found that two-thirds of this population participate in gay and lesbian social groups. It was also more likely for lesbians to participate in such groups than for gay males. Perhaps even more surprising was the fact that 80% would consider participating in a gay and/or lesbian only social organization sometime in the future.[6]

Older lesbians and gay males appear to feel that a safety associated with gay and lesbian organizations may not exist in other senior organizations. It is also likely that they see a far greater possibility for meeting new friends and finding new opportunities for relationships in a gay and lesbian social organization. A common complaint for older gay men is that they are vigorously pursued by older heterosexual women who are looking for mates and husbands. Frequently, older gay males — more than older lesbians — express a concern about their attractiveness to potential younger partners as they age. The insecurity of being viewed as old and ugly may lead older gay males to isolation and loneliness. In fact, Weinberg and Williams who surveyed more than 100 homosexual males (of whom one-fourth were over the age of 45) found that 59% of their subjects described themselves as lonely.[7] However, other studies have found loneliness to be a problem for relatively few older gay males as they age.[8]

Just as older gay males and lesbians want social interaction with other gay males and lesbians, they also want housing options with members of their community. In Kehoe's study of 100 lesbians age 60-85, almost two-thirds expressed a desire to live in gay or lesbian only housing.[9] Lucco found that almost 88% of homosexuals wanted housing that was somehow sensitive to gay and lesbian aging issues.[10]

Effect of Being Gay or Lesbian on the Aging Process

One of the most interesting questions that researchers have begun to address is whether or not being gay or lesbian has a positive or negative effect on one's aging process. In general, most recent studies of gay and lesbian research have discovered that subjects are happy, well-adjusted, and report high satisfaction concerning their current life situation. In some of the earliest research on the subject, Kimmel describes a coping mechanism for many older gay men and lesbians, which he calls "crisis competence." He theorizes that the coming-out process provides a sense of competence in handling crises which is called upon to buffer against the losses experienced in old age.

Not to be underestimated is the power of gay and lesbian networks of friends who are often considered as families. Berger asserted that being well-integrated into the gay community helped lead to greater self-esteem and a stronger sense of self worth for his study subjects.[11] Others have found evidence that the strength of networks of gay and lesbian friends and the involvement in a gay and lesbian culture could result in the insulation of gay men from losses that are associated with old age. Still other research suggests that gay men and lesbians exhibit greater flexibility with gender roles that may in turn lead to greater acceptance of one's aging, which can be at-

tended by a decline in the adherence to rigid gender roles.[12]

Conclusion

As today's gay men and lesbians become a more openly recognized part of the group referred to as "older adults," they will become more assertive about having their needs met by traditional social service agencies and programs. While homophobic attitudes may continue to exist in society, acceptance of gay and lesbian lives is growing both in the legal and in the social arena. One optimistic outcome of the small but growing body of research in this area suggests that being comfortable with one's sexual orientation can actually mitigate against the numerous stressors associated with old age.

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AIDS AND OLDER PEOPLE

Two Educational Models

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Education about HIV/AIDS prevention for older adults must be provided in a context in which it can be heard and understood. Community presentations, individual counseling sessions, and family support are essential to effectively changing knowledge, attitudes, and behaviors among senior citizens. In this article, we will offer two different educational models for the provision of HIV information and education to senior adults in service settings.

Individual and Family Counseling Education Model

Elder/Family Services is a mental health and case management agency located in Brooklyn, New York, which specializes in providing services to older adults and their families. It is the first agency of its kind in the country to receive Ryan White funding, specifically designated to target mental health and case management services to people over the age of 55 who are infected or affected by HIV. The population receiving service in this program includes men and women from a wide range of AIDS-related transmission risk, race, ethnicity, religion, sexual orientation, and cultural backgrounds.

It is important to begin by acknowledging that each age group or generation has a unique culture, set of beliefs, experiences, standards, morals, and language. When attempting to provide information to older adults in order to effect behavioral change, we must be able to understand the perspective of the person with whom we are attempting to communicate. Successful communication can only take place in a context in which all parties speak some form of a common language.

In one case, for example, the Puerto Rican grandmother of an eight-year-old boy with AIDS is a devout Pentecostal. During a counseling session, she was discussing her plans to take her grandson to a hands-on healing service in her church. While speaking, she vigilantly eyed the case worker for a response. The worker listened carefully and then validated this healing prayer service as a potentially helpful resource for the grandchild. The grandmother was surprised that the worker did not ridicule her for this belief in the power of prayer. She went on to explain that when she told her plans to a visiting nurse who had been working closely with the family, the nurse was harsh and judgmental. The discussion between the grandmother and the case worker then focused on the effectiveness of the combination of Western medicine, holistic healing, and spiritual beliefs. The contrasting approaches of these two healthcare providers indicate that building a level of trust and willingness to share can affect the success of disseminating information.

Valuing Cultural Beliefs

Professionals must respect and value the client's cultural and religious beliefs. Listening without judgment is a simple, effective way to indicate respect. Many older adults have very strong and sometimes conservative beliefs, particularly in relation to religion and spirituality. When discussing healthcare issues, many clients believe in the power of prayer, miracles, and healing. Whatever the belief of the worker or educator, it is essential to translate important HIV information (that is, our beliefs) into the client's language. If case workers continue to use their own language, they force the client to choose and can expect that the client will choose what he or she already knows, believes, and trusts to be true. For instance, if a client with AIDS believes he or she will be cured by prayer or healing, the case worker needs to use those ideas as a bridge to discuss medical care and prescribed medications. In the authors' experience with older adults, older people continually integrate new information into their lives while maintaining prior belief systems. Miracles, hands-on healing, and traditional native medicine can be a healthy combination with western medicine and therapies, enabling the client to utilize all methods that are available.

When working with older people, educators must also acknowledge and respect cultural sets that come with a given generation. Sexual mores and roles, appropriate language, the manner in which feelings are acknowledged and handled, family status and relationships all vary greatly, especially for those adults born before World War II. Additionally, a substantial number of older adults born and living in the U.S. now were forced to leave school prematurely in order to help support families. This sometimes results in weak literacy skills or discomfort with scientific and technical information.

Generational and Cultural Sensitivity

In earlier times, generations were taught to respect and defer to people in positions of authority and power. This can result in older people feeling intimidated when deal-

ing with professionals. Sometimes elderly clients are stiff and hesitant for fear of disclosing too much information or saying something "inappropriate" or embarrassing. Ultimately, this dynamic creates an untrustful environment which may limit a person's willingness to show vulnerability or be completely honest. It is helpful sometimes to work with younger family members who will support the older person in acquiring new information and understanding. Counselors, educators, and therapists can work closely with younger family members in order to bring them in to explain information and options. At the same time, involving the family reduces the isolation of the older family member. For couples, siblings, peers, and other family members, the older person can become a source of information and education as for contemporaries.

Frequently, clients are embarrassed to ask "stupid" questions or admit that they do not understand. It is important for the worker to probe carefully in order to assess the client's understanding of the information presented. When discussing issues relating to sexuality and sexual behaviors, workers must be sensitive to feelings of embarrassment and fear of disclosure. Free discussion of sexual behavior and lifestyles reemerged most recently as a phenomenon of the Sixties. Prior generations were raised to believe that it is crude and impolite to speak frankly about such issues. One was not supposed to "air dirty laundry" in public. Therefore, anyone outside of the immediate family is not to be let in on personal business. Many families do not openly discuss feelings and problems, even with each other. As a result, many older adults have never learned how to communicate directly about difficult times, personal feelings, and sexual issues. Healthcare workers often assume a client is "resistant," when a lack of awareness about how to communicate may be the real obstacle involved.

When educating older adults, the worker's understanding and faith in the elderly client's abilities is important. The following may be used as guides toward that understanding:

- The elderly client knows what is best for him or her;
- The elderly client can learn and integrate new information if it is translated into understandable language;
- The elderly client can gain skills necessary for self-advocacy; and
- The elderly client has a tremendous amount of life experience and knowledge.

By drawing comparisons between HIV/AIDS and other issues in the elderly client's life, the case worker assists the older person in utilizing existing coping skills. The understanding of what will be needed to cope and change in relation to the HIV/AIDS epidemic will follow. In working with older people, one must remain open to a generational and sometimes cultural difference in life experience and coping skills. It is essential, however, not to engage in ageist stereotypes. Acknowledge that belief systems tested by a lifetime of experience must be respected and used as a bridge for integrating new ideas and knowledge about HIV/AIDS.

Community Education: An Alternative Model

In addition to the opportunities available to older adults in terms of individual counseling, the workshop setting has been recognized as an important venue for HIV/AIDS education. A grant from New York State Department of Social Services in 1990 provided SAGE (Senior Action in a Gay Environment) an opportunity to offer HIV/AIDS education to older adults in publicly-funded senior centers in the five boroughs of New York City.

SAGE is a multi-service, social service organization committed to the needs of gay and lesbian seniors in New York City. SAGE serves as a social and educational center, provides comprehensive social services for gay and lesbian seniors who are homebound or confined to nursing homes and hospitals, and provides public education for professionals on the issue of aging for gay men and lesbians. In 1989, SAGE's AIDS and the Elderly program began providing case management, counseling services, on-going support groups for older persons with HIV/AIDS, and caretaker and bereavement support groups.

Some HIV/AIDS and aging service providers and educators have allowed the mythology of older adulthood to obscure the need for HIV/AIDS education and prevention strategies.

As part of its comprehensive program, SAGE has developed a model curriculum for educating seniors about HIV/AIDS. Employing basic concepts of adult education, the SAGE model provides a flexible, interactive forum in which older adults can participate in an effort to replace fear and misinformation with state-of-the-art HIV/AIDS information. Seniors are invited to think of themselves and of their roles as educators within their families and their communities. The workshop takes approximately one hour and focuses on basic facts about virology, basic immunology, transmission, symptomology, prevention, and the roles of the older adult as caretaker.

The curriculum addresses the problem of communicating difficult medical and biotechnical information by using analogies from the lives of the older adults in the audience. For example, many of today's older adults were raising their children during the polio epidemic of the 1950s. Many are able to remember clearly and express the fear they felt for their children's health during that period. By doing so, they are able to come to a better understanding of our current knowledge about airborne and non-airborne viruses and about infection control. Similarly, a discussion about aging and the immune system can lead to a better understanding of immune deficiency. The technique of exploring corollaries are proven to be effective for educating older adults about HIV/AIDS.

THE HIV/AIDS AND AGING TASK FORCE OF NEW YORK

AIDS is an Aging Issue

Created in 1991, the Task Force brings professionals from HIV/AIDS education and aging-advocacy networks together to address the impact of the epidemic on older adults. The Task Force emerged from the following: a concern for older adults and their families who are affected by AIDS; the need for comprehensive, chronic and continuing services for people with AIDS; and the need to educate older people about HIV disease.

As HIV/AIDS comes to be viewed as a chronic disease, ethical and policy issues of great importance are being raised and addressed by the Task Force. These include acute and long-term care services traditionally utilized by older people; segregated versus integrated care in long-term care facilities; impact on community-based agencies and the competition for scarce resources; the indirect impact on older people caring for relatives with HIV/AIDS.

The Task Force is committed to ensuring that the legitimate concerns of older people and their families affected by the HIV/AIDS epidemic are appropriately addressed and to generating educational, programmatic, and policy initiatives in the field of HIV/AIDS and aging.

For more information about the Task Force and its activities, contact Marie C. Nazone at (212) 481-7670, Brookdale Center on Aging, 425 East 25th Street, New York, NY 10010.

Aging Service Providers
Some HIV/AIDS and aging service providers and educators have allowed the mythology of older adulthood to obscure the need for HIV/AIDS education and prevention strategies. The assumptions that older adults are sexually inactive and not likely to use injection drugs, and so are at lower risk for HIV infection, have produced disastrous results. The assumptions that seniors are not interested or affected by the AIDS epidemic and are not open to frank and honest discussions of sexual matters have led us to underserve this population. In the first year of the SAGE program, staff expressed amazement at the willingness and openness with which seniors attended these workshops. Ironically, there was a great deal of absenteeism among senior center directors and program planners, from which it became clear who was experiencing the discomfort in discussing these issues.

Making the Connections
Older adults are vitally concerned about the state of the healthcare system in this nation. Many of us initially felt that seniors might perceive the HIV/AIDS epidemic as a drain on the system that already underserves them. However, it is our experience that a natural alliance is possible between aging advocates and clients and HIV/AIDS advocates and clients. The two groups, indeed, have similar agendas and have much to learn from one another in advocating for a more humane and comprehensive delivery of health care.

Karen Solomon is currently working as a program consultant. Before becoming HIV Coordinator at Elderly/ Family Services, she was the Director of Support Services at Body Positive, a New York City service organization for people with HIV, and the Coordinator of Anonymous Counseling and Testing for the New York City Department of Health, AIDS Program Services.

Gregory Anderson is a social worker in New York City who for many years has worked in gay and lesbian gerontology. He is a frequent contributor to local and national conferences and currently serves as co-chair of the HIV/ AIDS And Aging Task Force of New York.

News About Older Americans

Health data about older Americans were released this May by the Centers for Disease Control and Prevention. Some of the highlights are as follows:

- Life expectancy has reached an all-time high of 75.7 years.
- Most adults (about two-thirds) report no difficulty with activities of daily living.
- More elderly black females reported difficulties with activities of daily living than their white counterparts, but the difference according to race did not hold for males.
- Medicaid was the principal source of payment for 50% of the older population. For hospital discharges, self-payment was negligible (less than 1%).
- Death rates for disease of the heart and cerebrovascular disease declined in virtually all of the race-gender groups during the 1980s. Death rates for cancers increased due to more cases of lung cancer.

SEXUALITY IN MIDDLE AND LATER LIFE

A SIECUS Annotated Bibliography

Sexuality education is a lifelong process, involving physical and emotional changes throughout life. Sexual learning does not end at a particular point in life, but continues as people meet new challenges and gain new rewards at each stage of their development. The following is a list of books and other resources for general readers, health professionals, and educators. Though not exhaustive, it provides an introduction to the most current books about the sexual concerns of men and women over forty. SIECUS does not sell or distribute any of the materials listed in this bibliography. However, most titles are available for use at SIECUS' Mary S. Calderone Library.

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The American Association of Retired Persons (AARP) is making free copies of this bibliography available for distribution. For one free copy of the bibliography write to: AARP, Fulfillment, 601 E Street, N.W., Washington, DC 20049. Stock Number D15064.

GENERAL READERS

GROWING OLDER TOGETHER: A COUPLES GUIDE TO UNDERSTANDING AND COPING WITH THE CHALLENGES OF LATER LIFE
Barbara Silverstone & Helen Kandel Hyman

Written for couples over 55, this book addresses the challenges husbands and wives often face as they grow older. The authors discuss the problems associated with advancing years, including preparing for retirement, changing roles and autonomy, failing physical health, diminished mental capacity, and chronic disabilities. Given the dramatic rise in life expectancy, the authors include a comprehensive resource list of supplementary reading, family service associations, homecare agencies, and brief discussions of common medical problems. 1992, 344 pp., $15.00.

Pantheon Book/Random House, Inc., 400 Hahn Road, Westminster, MD 21157; 800/733-3000.

HOW TO FIND LOVE, SEX & INTIMACY AFTER 50: A WOMAN'S GUIDE
Dr. Matti Gershenfeld & Judith Newman

Written for the single, separated, widowed or divorced woman over fifty, this book discusses the issues surrounding dating and relationships in today's world. This self-help guide deals with ways to meet people, to overcome comparisons with previous partners, to strategize and deal with the many types of male personality, to cope with grown children's attitudes, and to define expectations and desires in new relationships. 1991, 308 pp., $9.00.

Ballantine Books/Random House, Inc., 400 Hahn Road, Westminster, MD, 21157; 800/733-3000.

HYSTERECTOMY: BEFORE AND AFTER
Winnifred B. Cutler

A detailed book about hysterectomy, menopause, and general health in midlife, with extensive references and appendices. This text can be used as a reference for counselors and other providers of health care and social services. 1990, 646 pp., $10.95.

Perennial/Harper Collins, 10 E. 53rd Street, New York, NY 10022; 800/242-7737.

LONG TIME PASSING: LIVES OF OLDER LESBIANS
Marcy Adelman, Editor

Older lesbians tell their life stories and explain how they have changed as they have passed from youth to older age. Though not a systematic study, this book offers many memorable accounts of lesbians adapting to advancing years. Includes an appendix with further readings on health, legal, and social supports for older lesbians. 1986, 260 pp. $7.95.

Alyson Publications, 40 Plympton Street, Boston, MA 02118; 617/542-5679.

MENOPAUSE, NATURALLY: PREPARING FOR THE SECOND HALF OF LIFE
Sadja Greenwood & Marcia Quackenbush

This informative common-sense guide gives a balance of holistic and medical approaches to health care, addressing cultural influences and biological facts about menopause and aging. Contains information about Estrogen Replacement Therapy and emphasizes general health care, exercise, and nutrition. 1992 revised edition, 202 pp., $13.95.

Volcano Press, 330 Ellis Street, San Francisco, CA 94102; 209/296-3445.

OURSELVES, GROWING OLDER
Paula Brown Dorress & Diana Laskin Siegal

Written in cooperation with the authors of "The New Our Bodies, Ourselves," this book covers physical, emotional, social, and sexual health after early adulthood. It offers useful lists of resources about sexuality, love, relationships, and the many social, economic, legal, and lifestyle issues that affect sexuality and intimacy in the later years. 1987, 511 pp., $18.00.

Touchstone/Simon and Schuster, 1230 Avenue of the Americas, New York, NY 10021; 800/223-2348.

THE POTENT MALE: FACTS, FICTION, FUTURE
Irwin Goldstein & Larry Rothstein

A straight-forward book about the causes of, and medical treatment for, erectile dysfunction, which can occur at any age. The authors, a urologist and a medical writer, review the subject in detail and explain the advantages and disadvantages of various treatment strategies. Resource lists and bibliography are included. 1990, 210 pp. $12.95.

Putnam Publishing Group, 390 Murray Hill Parkway, East Rutherford, NJ 07073; 800/847-5515.

SECOND HONEYMOON: A PIONEERING GUIDE FOR REVIVING THE MIDLIFE MARRIAGE
Sonya Rhodes

This book addresses the impact of midlife on couples and the specific issues partners face that can crucially affect their marriages. The book focuses on the premise that most people are looking for a way through the crisis — not out of the marriage. The author describes the high-risk roles and behavior patterns spouses bring with them into midlife and the kinds of collusion couples use for resisting the change that is normal and necessary for growth. 1992, 287 pp., $20.00.

William Morrow & Company, Inc., 1350 Avenue of the Americas, New York, NY 10019; 800/843-9389.

SEX IN THE GOLDEN YEARS
Deborah Edelman

This informative guide is based on extensive research and filled with personal anecdotes and first-person narratives. Experts in the field are interviewed, as well as older Americans who speak frankly about their feelings and life situations. 1992, 222 pp., $21.95.

Donald I. Fine, Inc., 19 West 21st Street, New York, NY 10010; 800/526-0275.

SEX OVER 40
Saul H. Rosenthal

This book offers practical, fact-filled advice about how menopause, prostate enlargement, and other age-related medical conditions affect adult sexuality. The author reveals the causes of and cures for diminished potency, examines the effects of diabetes, high blood pressure, arthritis, and alcohol use on sexuality, assesses procedures such as estrogen and testosterone replacement, explains the effects of prescription drugs, and recommends practical treatments and strategies for many different conditions. An extensive section is devoted to the psychological aspects of sexuality for older people. Creative lovemaking techniques are also suggested for enhancing relationships between men and women. 1987, 267 pp., $9.95.

Jeremy P. Tarcher, Inc. 5858 Wilshire Boulevard, Suite 200, Los Angeles, CA 90036; 800/631-8571.

SEXUAL HEALTH IN LATER LIFE
Thomas Walz & Nancee Blum

This book offers a positive approach to sexual activity for the older adult. The authors discuss the effects of the aging process, chronic illness, medical treatment, and individual attitudes and mental states on sexual desire and capacity. Alternative sexual positions for individuals with physical limitations are clearly illustrated. 1987, 144 pp., $9.95.

Free Press/Macmillan Publishing Co., Front & Brown Streets, Riverside, NY 08375; 800/257-5755.

SOLITUDE
Anthony Storr

Being and feeling alone can occur at all ages but happens with particular force during the second half of life. Storr writes that our society, which greatly values relationships, often ignores the creative, sustaining, and healing powers of solitude. This book, filled with philosophical observations and clinical insights, offers good information on lifestyles in the later years. 1989, 216 pp., $9.95.

Ballantine/Random House, 400 Hahn Road, Westminster, MD 21157; 800/733-3000.

STAY COOL THROUGH MENOPAUSE
Melvin Frisch

This complete and detailed medical book about menopause is written by a physician in question-and-answer format. Glossary and references are included. 1989, 276 pp., $9.95.

Putnam Publishing Group, 390 Murry Hill Parkway, East Rutherford, NJ 07073; 800/847-5515.

UP FRONT: SEX AND THE POST-MASTECTOMY WOMAN
Linda Dackman

An honest account of one woman's experiences after being diagnosed with breast cancer. Covers issues of self-esteem, sexual attractiveness, self-acceptance, and fear of rejection. 1990, 114 pp. $17.95.

Viking Penguin, P.O. Box 120, Bergenfield, NJ 07621-0120; 800/526-0275.

VENUS AFTER FORTY: SEXUAL MYTHS, MEN'S FANTASIES, AND TRUTHS ABOUT MIDDLE-AGED WOMEN
Rita Ransohoff

Drawing upon "bar jokes," limericks and other tales to illustrate the many myths about older women, the author explores fallacies, fantasies, and new options for women over forty. Values, attitudes, and patterns of behavior are examined. 1990, 289 pp., $11.95.

New Horizon, P.O. Box 669, Far Hills, NJ 07931; 800/533-7978.

HEALTH PROFESSIONALS AND EDUCATORS

GAY MIDLIFE AND MATURITY: CRISIS, OPPORTUNITY & FULFILLMENT
John Alan Lee, Editor

This monograph, published originally in the *Journal of Homosexuality*, challenges long-held stereotypes about aging gay men and lesbians. Topics include the adjustment of gay and lesbian persons to later life, theories of successful aging, a comparison of the traditional gay community versus the organized gay community, and the sexual attitudes and behaviors of older gay men. 1991, 233 pp., $24.95 hc, $16.95 pb.

Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1508; 800/342-9678.

GEROSEX
Robert Gemme & Jean-Marc Samson, Editors

This is an extensive bibliography of books and articles on sexuality and aging. It includes a listing of French and English articles from hundreds of American, Canadian, French, and Australian journals (1940-present), and monographs and dissertations. The book is updated periodically by the editors, who are associated with the graduate sexology program at the University of Montreal. 1988, 154 pp., $25.00.

Robert Gemme, Department of Sexology, University of Quebec at Montreal, Casse Postale 8888, Montreal, H3C 3P8, Canada.

LESBIANS OVER 60 SPEAK FOR THEMSELVES
Monica Kehoe

This monograph, originally published in the *Journal of Homosexuality*, provides demographics and explores the thoughts and feelings of lesbians about aging and lesbianism, coping with homophobia, and the effects of these on sexual behavior. 1989, 111 pp., $22.95.

Haworth Press, Inc. 10 Alice Street, Binghamton, NY 13904-1580; 800/342-9678.

MEN AND DIVORCE
Michael F. Myers

This book describes the impact of divorce on men's sexuality and relationships, as well as on the people close to them. Although written for mental health professionals, this book will interest serious non-specialists. Topics include divorce at various ages, abandoned husbands, divorcing men who come out as homosexuals, divorced men's relationships with their children, therapeutic approaches, and common themes in treatment. 1989, 286 pp., $32.95.

Guilford Press, 72 Spring Street, New York, NY 10012; 800/365-7006.

PRINCIPLES AND PRACTICE OF SEX THERAPY: UPDATE FOR THE 90s
Sandra R. Leiblum & Raymond C. Rosen, Editors

This revised second edition includes an in-depth chapter about sex therapy with aging adults. Additional information on older patients appears throughout the book in chapters that focus on various problems of men, women, and couples. A detailed bibliography is included. 1989, 413 pp., $38.95.

Guilford Press, 72 Spring Street, New York, NY 10012; 800/365-7006.

SEXUALITY AND CHRONIC ILLNESS
Leslie R. Schover & Soren Buus Jensen

This comprehensive book reviews normal sexual aging and the sexual effects of common medical problems and procedures in middle and later life including diabetes, cardiovascular illnesses, hormone replacement therapy, arthritis, cancer, and chronic pain. It emphasizes the helpfulness of psychological counseling along with medical treatment. Ethical issues, cooperation by medical and non-medical personnel, and health care training are also discussed. Contains an extensive bibliography. 1988, 357 pp., $45.95.

Guilford Press, 72 Spring Street, New York, NY 10012; 800/365-7006.

NEWSLETTERS

CONVERSATIONS
Carol B. Hittner, Editor

Written for adults over forty, this personal monthly newsletter focuses on positive aging, using stories and first-person accounts about sex and midlife changes. Rekindling one's sensuality, continued sexual growth and gratification, and comprehensive medical information are just a few of the subjects covered. Annual Subscription, $36.00.

Conversations, P.O. Box 1071, Melbourne, Fl 32902-1071; 800/447-9171.

SEX OVER FORTY
E. Douglas Whitehead & Shirley Zussman, Editors

This practical monthly newsletter contains short articles and news items about the sexual and reproductive systems, sexual function and dysfunction, the effects of illness and medication on sexuality, and relationships in middle and later life. Annual subscription, $36.00.

PPA, Inc., P.O. Box 1600, Chapel Hill, NC 27515; 919/929-2148.

ARTICLES

APPRECIATING THE SEXUAL YOU

This four-page article discusses how aging offers men and women a chance to understand each other better and how to find greater sensuality together.

Modern Maturity Magazine, April/May, 1992. AARP. For one free copy write: AARP/Fulfillment, 601 E. Street, N.W., Washington, DC 20049. Stock Number D14883.

VIDEOS

MENOPAUSE AND BEYOND
Dr. Judy Seifer

Menopausal women and their partners share their feelings about menopause and how aging has affected their sexuality and health in general. Specific topics include osteoporosis, the pros and cons of hormone therapy, urinary incontinence and the value of Kegel exercises. 1992, 60 minutes, $29.95.

Focus International, Inc. 14 Oregon Drive, Huntington Station, NY 11746; 800/843-0305.

SEX AFTER 50
Dr. Lonnie Barbach

This video confronts myths and stereotypes about older people, encouraging honest discussion of sexual feelings. The program deals with topics such as lack of desire, menopause, hormone replacement therapy, chronic illness, effects of medication, erection difficulties, loss of a partner, and inability to communicate. 1991, 90 minutes, $39.95.

Focus International, Inc., 14 Oregon Drive, Huntington Station, NY 11746; 800/843-0305.

THE HEART HAS NO WRINKLES

The love story of Mary and Derek, residents of a nursing home, makes clear that sexuality is not exclusively the province of the young. The way sexuality is expressed and its relative importance may change with age, but it remains an essential part of each individual's life. This video is a reminder to healthcare providers that emotional and physical concerns related to sexual function are an integral part of elder care. 1989, 16 minutes. Rental $65.00/3 days, $100.00/5 days. Purchase $250.00.

The Carle Foundation, Carle Media, 611 West Park, Urbana, IL 61801; 217/384-4838, FAX 217/384-8280.

SIECUS Bibliographies Available

- Sexuality and Disability
- Gay Male & Lesbian Sexuality
- Sexuality & Family Life Education
- Sexuality Education Resources for Religious Denominations
- Religious Perspectives on Sexuality
- Sexuality in Middle and Later Life
- Current Books on Sexuality
- Sexuality Periodicals
- Safer Sex and HIV
- Children, Adolescents and HIV/AIDS Education
- Current Resources for HIV/AIDS Education
- HIV/AIDS Audiovisual Resources
- HIV/AIDS
- Growing Up
- Talking with Your Child
- Child Sexual Abuse Education, Prevention and Treatment

•NEW BOOKS•NEW BOOKS•NEW BOOKS•

THE JANUS REPORT ON SEXUAL BEHAVIOR
Samuel S. and Cynthia L. Janus
New York: Wiley & Sons, 1993, $24.95

I suspect that many of us have been looking for a book which might chronicle what *The Janus Report* purports to do. Unfortunately, we will have to keep looking. Since the Reagan and Bush administrations consistently derailed federal funding for sexological research, there has been a need for what the Januses promise on their book jacket: "The first broad-scale scientific national survey since Kinsey."

"Broad-scale scientific" suggests a rigorous sampling procedure. The Janus study, however, was not rigorous. "Questionnaires were distributed," the authors assert, "to subjects at a wide variety of sites." Which? How? Who? Why? But the answers to these questions is silence. Even though there may be a similarity between the respondents and the U.S. census data in terms of geography, residence, age, marital status, and education, the undefined methodology suggests that the book represents nothing more than the individuals surveyed. It may be broad-scale, but it is certainly not scientific. Moreover, while the authors indicate that diverse racial and ethnic groups were included in the survey, they chose not to report their findings using those specifications.

Despite substantial misgivings, I proceeded through the first half of the book in the belief that, even if the samples were not representative of any particular population, perhaps some useful insights might emerge. While the puzzling organization of the book did not make this task especially simple or rewarding, I plunged in with eager hope to gain some wisdom from a book that promised so much.

Finally, perplexed by the remarkably imprecise language used to analyze some data, I turned to the questionnaire itself, reprinted in the back of the book. This is where I discovered the second major problem with this amateurish attempt at sexological science. The survey signified the old computer motto: GIGO (garbage in, garbage out). In fact, the questionnaire was doomed by its imprecise and ambiguous language. Among key questions about the respondent's sexual practices were the following:

"Have you had full sexual relations?" (H15) I believe this means sexual intercourse.

"I have orgasms during lovemaking." (D6) Lovemaking is not defined.

"I had sexual experience before marriage (D10)...at work..." (D11) Does kissing qualify as sexual experience?

"Have you had homosexual experience?" (H17) Again no definition concerning the range and type of experience is offered by the authors of the survey.

"To successfully function sexually, I fantasize not at all....slightly....etc." (D7)

The questions about oral sexual activities do not differentiate between giving or receiving, or between fellatio and cunnilingus. (D12)

I finally gave up reading any further.

Reviewed by Robert Selverstone, Ph.D., licensed psychologist and President of the SIECUS Board of Directors.

CURES: A GAY MAN'S ODYSSEY
Martin Duberman
New York: Dutton, 1991, 305 pp., $19.95

Martin Duberman's autobiography of his first forty-five years is a remarkable view into the psychological treatment of homosexuality prior to 1973, and the gradual liberation of gay men and lesbians from repressive philosophy. In lucid prose, *Cures* chronicles its author's transformation from a guilt-ridden young man searching for a "cure" into a leader in the movement to liberate lesbian and gay people. His transformation toward self-acceptance is, in the end, the ultimate cure.

Martin Duberman is currently a Distinguished Professor of History at Lehman College and the City University of New York Graduate Center, where he co-founded the Center for Lesbian and Gay Studies (CLAGS). In his acclaimed biographies of Charles Francis Adams (1963) and Paul Robeson (1989), Duberman interweaves strong analyses with wonderful prose. Beginning in 1972 with his landmark *New York Times Book Review* article on homosexuality and psychoanalysis, Duberman and colleagues pioneered the field of gay and lesbian history. Most notably, he has written *About Time: Exploring the Gay Past* (1986) and co-edited the marvelous compilation, *Hidden from History: Reclaiming the Gay and Lesbian Past* (1990). *Cures* personalizes history while continuing to investigate the role of psychology in defining gay and lesbian lives.

Born in 1930 in New York City, Duberman was taught by his parents what he terms "the important traits for a successful life in scholarship." These traits include a capacity for isolation, a compulsive and perfectionist nature, and a well-developed sense of fairness. He gained these, however, at the expense of a personal history. Duberman complains that his parents never divulged their own personal histories of Russia, the Holocaust, or immigration to the U.S., leading him to carry around "an enormous blackboard eraser suspended down my back to the floor, which, as I walked, instantly erased all traces of my footsteps." Thankfully for readers, the eraser was less successful than the image suggests, because Duberman chronicles a gripping, even dramatic story, about being a gay man and an academic in America between 1948 and 1975.

The central theme of the book is Duberman's struggle to find a "cure" for his homosexuality. From a gypsy at the Calgary Stampede in 1948 to Swami Satchadananda at the Integral Yoga Institute in 1971, Duberman sought out a series of commonplace and unusual therapies for his "failure" to be normal. The contemporary dilemma for lesbian and gay people, as prescribed by the psychiatric fraternity and the popular culture, was summed up in a Duberman diary entry in 1957: "The prospects of a lasting homosexual relationship are too slim for me to get much comfort from the possibility; and a satisfying heterosexual relationship is still so remote that I can barely even wish for it. But perhaps either luck in the first area or [help from a current psychiatrist] in the latter will make one or the other come true. In the meantime, I remain skeptical and unhappy."

Throughout the 1950s and through much of the 1960s, the popular media reinforced the notion of the homosexual as the outsider, the deviant, the pervert. In the McCarthy era, homosexuals were hounded from public service, quietly separated from academic institutions, and encouraged by a generation of psychiatrists and psychologists to "convert" to heterosexuality. As late as 1966, *Time* magazine "reported" that homosexuality was a "pathetic little second-rate substitution for reality, a pitiable flight from life...." Hollywood rejected sympathetic portraits of gay men and lesbians, opting for such portrayals as that in *The Children's Hour*, where a lesbian schoolteacher commits suicide.

Duberman admits that he had internal-

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ized this homophobia to such an extent that in 1968 he could negatively review Mart Crowley's *Boys in the Band*, not because it was self-hating, but "because I thought it romanticized the bravery and wit shown by the Boys...and would thereby 'help to confirm homosexuals in the belief that theirs is merely a different not a lesser way.'" Lesbians and gay men were under constant pressure to conform, resulting too often in a loss of sympathy for each other and themselves.

Duberman's saga with "Karl," his primary psychiatric influence in the mid-1960s, is a frightening indictment of contemporary theories and practices. Karl, whom we later discover engaged in sexual intercourse with his female patients and married one particular wealthy woman, challenges Duberman to reject his "adolescent" need for lust and to focus on developing "adult" priorities for love, which Karl defines solely in heterosexual terms. In ending his questioning of authority and recognizing that "homosexual love just doesn't work," Duberman would be able to love a woman and gain the security and satisfaction of a mature, adult, heterosexual relationship.

Gradually, though, Duberman comes to recognize the trap into which Karl and his colleagues have led him, and he begins to question them more closely on their motives and their successes in "converting" men to heterosexuality. Suddenly, it "was all beginning to unravel...." In place of his search for a "normal life," Duberman cautiously joins the gay liberation movement. He feels unfamiliar openly defending gay men and lesbians, but finds his niche in the Gay Academic Union. Within a few short years, the tortures of a lifetime are first questioned, then rejected. Duberman emerges as a liberated gay man, entering into a stable, loving relationship with a man and embarking on pioneering efforts in lesbian and gay history.

Two aspects of the narrative bothered me. First, Duberman discusses many of the actions and characters in the early gay and lesbian movement, but he does not effectively integrate the concepts of the historical movement into his narrative. I would suggest that 1950s American ideals of masculinity were so repressively defined at least partially due to the specter of an alternative definition. Kinsey's scale, with its legitimatization of bisexuality and homosexuality along with heterosexuality, symbolized that alternative, which is one reason one of Duberman's Yale professors wrote, "I don't like Kinsey. I don't like his report; I don't like anything about it." The persistent need to "convert" homosexuals to non-threatening heterosexuality suggests that the concept of masculinity was not as secure as Duberman suggests.

Second, Duberman never explicitly contrasts his earlier search for a "cure" and his eventual liberation. The narrative leaves the suggestion that gay liberation was the final cure, the fulfilled cure. I wonder if this does not just continue to allow the psychologists to set the agenda for gay men, lesbians, and heterosexuals of both genders. Liberation should mean the right, even the obligation to set a personal agenda.

Cures is an enlightened and exhilarating exploration into gay life in the post-war period. Duberman's odyssey was shared by a generation of lesbians and gay men. His book is a wonderful evocation of the destructive obstacles that generations of gay men, lesbians, and bisexuals have confronted and their determined struggle for liberation from a homophobic world and heterocentric medical profession.

Reviewed by David C. Sloane, Assistant Professor, School of Urban/Regional Planning, University of Southern California; Adjunct Assistant Professor, Community and Family Medicine, Dartmouth Medical School.

THE EROTIC SILENCE OF THE AMERICAN WIFE
by Delma Heyn
New York: Turtle Bay, 1992, 304 pp., $22.00

Does marriage rob women of their sense of self, their zest, unique ideas, sexiness? The chorus of voices from women having affairs, as interviewed in *The Erotic Silence of the American Wife*, is yes, but it is difficult to tell if the author was the orchestra leader for this consensus of thought.

Delma Heyn, a journalist, has provided a feminist thesis on women, affairs, and marriage. It is a bold and original assessment of the meaning of extramarital sex for women. The problem, to Heyn, is that marriage — or at least the over-idealized vision of marriage purported to exist in most women's minds — causes all too many to try to be the "perfect wife." Nice, selfless, good, the women interviewed say they conform to what they think their husbands want, losing their own identity in the process. Heyn describes "her" women as brave revolutionaries. "The band of outlaws I interviewed, the intrepid women...left the safety of conventional goodness...and by leaving it they recovered not only their capacity for pleasure but an amazing vitality and clarity."

This perspective is the book's strength and its chief flaw. The message of rediscovery is powerful, but the words of the women quoted by Heyn begin to sound suspiciously similar. A clue is found in Heyn's active, two-way interviewing: conversations in which she shares her ideas with the interviewee, perhaps with the natural enthusiasm of one possessed by an important insight. The worry is that her thoughts have had a subtle influence on her subjects.

Heyn can be heavy-handed in making the case for the possible benefits women derive from having affairs. The woman are "transformed," become more "adult," think more clearly, feel more energetic, focused, assertive — and sexy. It starts to sound like the newest way to achieve self-actualization, almost a requirement for the truly liberated woman. Near the end of the book, however, Heyn seems to take a few steps back from her own thesis, confessing that some women may actually be able to achieve all these benefits without extra-marital affairs.

While too polemical, the book's perspective on the energizing impact of an extramarital affair is certainly true for some women and perhaps partially so for most if not all who choose this path. As one of Heyn's subjects reflects on life with her husband after her affair is over: "And sex?" asks Heyn. "Well," answers the woman, "it's sometimes terrible and it's sometimes good, you know, the way sex always is."

Reviewed by Lorna Sarrel, MSW, Co-Director, Human Sexuality Program, Yale University and the Vice President of the SIECUS Board of Directors.

SACRED ORGASMS
by Kenneth Ray Stubbs
Berkeley: Secret Garden, 1992, $18.95

For professionals in the sexology and sexuality education fields, it is important to know not only what people do sexually, but also how their sexuality is defined and integrated in their total life experience, world-view and spiritual commitment. *Sacred Orgasms* by Kenneth Ray Stubbs is an important book that offers valuable insight into the contemporary fusion of spirituality and sexuality.

Through text and illustrations, Stubbs focuses on the orgasm as a vehicle for

spiritual enlightenment. Inspired in part by traditional, cultural understanding of sexuality, the book is also the journey of a man whose work in massage, particularly erotic massage, opened the doors to communication with the self and others. The author relies upon an extended outline writing style, supported by beautiful photographs of sexual positions and rituals, carefully arranged to conceal the genitals and penetration. The format allows readers to move quickly back and forth through the pages. Stubbs's style is mostly a success, although he excludes photographic portrayal of masturbation and homosexuality. Additionally, some parts of the text are difficult reading. An extensive use of connected words and hyphens, in an effort to be holistic, takes some getting used to.

Sacred Orgasms is divided into three sections: "Contemporary Sexuality," "Four Traditions," and "Energy." The first section reminds us that sex is more than intercourse and orgasm and that translation of spirit and body into sacred and profane is a mistake. Orgasm is a vehicle to transcend and discover hidden, ultimate meaning. While much Western thinking is bridging these mind and body concepts, the Roman Catholic Church's recent catechism permitting only a moderate amount of pleasure during intercourse reminds us of the distance yet to travel.

"Four Traditions" describes the sexual elements of two Eastern traditions (Tantra and Taoism), Quodoushka from the Cherokee culture, and Meditative Massage. Each ritualizes sexuality as a means to spiritual enlightenment, including experiencing out-of-the-ordinary orgasm. This moves beyond the customary Western interpretation, which usually defines orgasm as a muscular tension release. Stubbs, however, tends to overdescribe these extraordinary orgasms. The attempt to be all-inclusive unnecessarily dilutes the focus of the book. Here is where the book's weakness is most apparent: a lack of critical examination of the various traditions and a tendency to redefine to the point of exhaustion. It is unfortunate that a yoga tradition which sees women as disposable vessels for male enlightenment should be held up as the model for spiritual sexuality. From the Tantra tradition is drawn the concept of acceptance, chakras, and meditative sexuality. More time is spent on Tantra than is perhaps necessary, and the same may be said for Taoism, from which is drawn the concepts of harmony, balance, and non-attachment to the glandular systems.

"Energy" operates on the new definition that orgasm is more than physical release and is, in fact, energy-generating. To make this point, Stubbs presents his interpretation of several "systems" within us which are apparent and hidden, gross and subtle. Orgasm functions uniquely upon each system, providing pleasure in one, generating energy in another, and integrating all systems in the third.

Sacred Orgasm closes with these words:

"To the extent
we deny our spiritual nature
we limit our sexual nature
To the extent
we deny our sexual nature
we limit our spiritual nature."

Looking to the other side of this coin, we could read as follows:

"To the extent
we affirm our spiritual nature
we expand our sexual nature
To the extent
we affirm our sexual nature
we expand our spiritual na
ture."

This new outlook on orgasm is a useful tool for professionals in the sexuality field who need to know not only what people do sexually but also to understand how their sexuality is defined. Few may share the interpretation given in *Sacred Orgasms,* but its lessons may provide guidance to those seeking to fuse the sexual and the spiritual.

Reviewed by Laird Sutton, Ph.D., Director of Instructional Media, The Institute for Advanced Study of Human Sexuality.

ASK ME ANYTHING: A SEX THERAPIST ANSWERS THE MOST IMPORTANT QUESTIONS FOR THE 90'S
Marty Klein
New York: Simon and Schuster, 1992, 339 pp., $11.00, pb.

Concerns about sexuality — as a partner, parent, educator, friend, or consumer — are largely addressed in *Ask Me Anything,* a comprehensive, enjoyable, and easy-to-read guide for adults. In a well-organized question-and-answer format, presented in a humorous yet still sensitive manner, the author attempts to supply information and offer advice and reassurance. For the most part he succeeds at both tasks. The overwhelming message in Klein's book is that of taking responsibility for our sexuality through the following strategies: access to sexual knowledge, communication of our sexual desires, comfort with individual differences, and prevention of sexual coercion or humiliation by partners.

Extensive cutting-edge information is provided in sections on the body, arousal, intimacy, concerns, and parenting. The chapter about sexual concerns covers sexual dysfunction, sequelae of rape, and information about recent psychosocial and medical advances in sexual therapies. The arousal section reviews technique, fantasy, masturbation. Other chapters address intimacy, communication, monogamy, homosexuality, body image, menstruation, contraception, and sexual health. An especially well-written chapter covers changes associated with aging.

A focus of the book concerns self-acceptance. In his introductory chapter, Klein describes "normality anxiety," which is based on sexual insecurities that our sexual behavior or equipment is not normal. Klein stresses that any behavior is normal so long as it involves consenting participants, is non-exploitative, and is not self-destructive. In response to common questions about size and shape of sexual organs, Klein explains that these variables are unimportant to ability to perform sexually or to share sexual enjoyment with one's partner. Klein does an especially good job of addressing issues of self-acceptance, in which the narrative gently encourages the reader to appreciate his or her individual differences as a way of enhancing body image.

Klein emphasizes the importance of partner communication. He acknowledges cultural, inter-personal difficulties with discussing sexuality. Because no one can read his or her partner's mind, Klein offers concrete examples of how to begin a discussion about sexual activity and how to handle both positive and negative feedback from a partner. Klein even focuses on communication between doctor and patient, noting that many doctors are not comfortable asking about sexual concerns. Sometimes, the burden falls upon the patient to raise the matter.

Two chapters are notably less helpful. The section on spirituality remained unclear after several re-readings. Klein describes a spiritual level of sexuality but never tells us what we are supposed to do in order to "transcend" to that plateau. Additionally, this chapter hints that our current ways of expressing sexuality still do not make the grade. Yet, unlike

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Klein's phrasing throughout the rest of the book, this chapter is vague. The least he could have done was to tell the reader how to reach this transcending pleasure.

The other chapter of concern involves Klein's views on monogamy. Klein describes those who value monogamy as fearing abandonment, having low self-esteem, and being prone to jealousy. Speculating that monogamists are unhealthy and manipulative, Klein states that "monogamy is harder for many men than it is for many women," without substantiating this view with theory or data. Even if more men are non-monogamous, it does not necessarily follow that women find monogamy easier to maintain. Klein also neglects to point out the pitfalls of affairs outside of primary relationships, including disrupting relationship trust, and causing anger and resentment within the bounds of the family or relationship. Had Klein dealt with these, the reader would have been better served.

These two points aside, the book is a good reference guide to sexual health and a healthy relationship. The easily-consumable and informative writing style is recommended for those interested in learning more about sexuality, enhancing relationships, or addressing sexual concerns.

Reviewed by Ilana P. Spector, Ph.D. Spector is currently working as a postdoctoral research associate at the Center for Sexual and Marital Health at the University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School in Piscataway.

A COMPLETELY NEW LOOK AT INTERRACIAL SEXUALITY: PUBLIC OPINION AND SELECT COMMENTARIES
Lawrence R. Tenzer
Manahawkin: Scholar's Publishing House, 1990, 196 pp., $16.95 pb.

With interracial dating and marriage ever on the rise, *A Completely New Look at Interracial Sexuality* makes a timely appearance. Lawrence R. Tenzer's thorough and scholarly work on interracial sexual relations — past and present — is the most valuable contribution to the professional literature since J.A. Roger's *Sex and Race*, published some 50 years ago. Both works cover a broad spectrum of interracial sexual topics.

The first two chapters of Tenzer's book consist of a landmark public opinion survey which examines the beliefs American white women have about interracial sexual relations. Until now, all studies conducted in this area have focused solely on the individuals and couples personally involved in such relationships. If there can be one criticism of Tenzer's book it is his weak justification for his choice of study population. He writes, "The issue of white women dating and marrying black men has always been at the center of the controversy surrounding interracial sexual relations in America." Tenzer does clarify his position by stating that "the beliefs of white men, black women, and black men as other populations at large are valid as well, but in order to limit the scope of the present study their beliefs had to be left out for future research."

White women in a national probability sample were surveyed about their beliefs on a variety of interracial sexual issues. Such questions included whether the respondents believed that more white men than white women had interracial sex; what the respondents believed the legal prohibitions to be; whether the respondents believed that white men think there is a sexual difference among races; and whether or not the respondents believed interracial sexual relations to be the root of racial prejudice in America. The data obtained from the survey are presented in easy-to-read charts with various demographic categories.

The remaining eight chapters of Tenzer's book consist of commentaries which objectively examine each of the survey issues within a broad socio-historical context. Tenzer uses "interracial sexuality" as an all-inclusive term and a vehicle through which to approach the subject matter. Although specifically worded in terms of the relations between whites and blacks, much of the subject matter is equally applicable to interracial sexual relations of all kinds. It is important to note, however, that the book is strictly heterosexual in its orientation.

Rather than consider interracial sexual relations within a greater purview of sexual relations in general, Tenzer specifically limits his discussion to the interracial component. For example, when delving into the whys and wherefores of interracial dating and marriage, he does not address love, security, spite, revenge, or other human motives which may also apply to intra-racial relationships. Instead, the focus is placed on attraction to the exotic, the forbidden fruit syndrome, and the notion of an unresolved Oedipus complex.

Portions of the text provide excellent historical perspectives about the evolution of American sexual relations. Although some readers may feel that too much history has been included for a book on sexuality, the work proves to be quite helpful in understanding the role that slavery played in sexuality between whites and blacks. Of particular interest is the detailed explanation of how the ideology of "mulatto inferiority" developed prior to the Civil War and its legacy afterward.

Each of the commentaries in Tenzer's book is followed by an exhaustive bibliography — perhaps the book's greatest value. Counselors, therapists, health practitioners, psychologists, sociologists, teachers, and students who are looking for literature on interracial sexual issues will find these bibliographies a gold mine of reference material. The book would make an excellent supplementary college text for classes in human sexuality, women's studies, and black studies, in particular, as well as psychology and sociology. *A Completely New Look at Interracial Sexuality*, the only book of its kind, is an impressive contribution to the professional literature.

Reviewed by Gabe Grosz, Associate Publisher of Interrace Magazine, *Beverly Hills, California.*

BOOK REVIEWERS NEEDED

If you are interested in reviewing books or videos on sexuality issues, please send your name, affiliation, special interest, address, phone number and fax number to:

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NEW YORK, NY 10026
OR FAX (212) 819-9776

If you've read a good book or watched an educational video concerning sexuality, write and tell us about it.

PUBLIC POLICY UPDATE

"Wake Up Call"

Betsy Wacker and Alan E. Gambrell
Director of Public Policy and Washington, DC Representative, SIECUS

The excitement of the November election and the inauguration of the new administration has begun to die down. National advocacy groups with a focus on sexuality rolled up their sleeves and set to work concerning abortion, sexual orientation, contraception, and sexuality education. While conservatives are busy trying to salvage past policy changes and recreate avenues to power they previously enjoyed in Washington, D.C., sexuality advocates are pressuring President Clinton for more action. His early decision to dismantle anti-choice legislation and his early promise to lift the ban on gays and lesbians in the military, now weakening, are not enough. The Far Right has been far from silent, employing every strategy from grassroots activism, increased fundraising, media blitzes, and political activity on state and local levels. In the New York City Board of Education elections, conservatives mailed hundreds of thousands of voter guides identifying their hand-picked candidates as standing for "family values."

Numbers Tell A Story: Or Do They?

The Alan Guttmacher Institute recently published a survey about sexual behavior reporting that one percent of American men aged 21-39 identify themselves as exclusively gay. Kinsey's much-quoted 10% figure was called into question, not for the first time, but perhaps more publicly than ever before. While the classification, "exclusively gay" probably encompasses a small percentage of the population, a debate has ensued about how many Americans are gay or lesbian and what behaviors define sexual orientation. The debates, however, have not so much reflected the question of exclusivity in choice of sexual partner as a definition of homosexuality, as much as they have exposed the need for national sexual behavior research. The NIH reauthorization bill, which would allow such research, is still on hold in Congress. Fundamentalist forces have for many years stalled efforts to undertake large-scale studies, the immediate need for which is to improve the design of HIV/AIDS, and STD prevention education programs. SIECUS is working to overcome such stall tactics.

The March and The Military

Numbers, of course, also carry social and political weight. It is estimated that somewhere between 300,000 and 1 million activists turned out for the gay and lesbian march in Washington, D.C. Attention by attendees was given to Colorado's anti-gay Amendment 2 and the ongoing debate concerning gays in the military. Gay and lesbian military hearings are still under way in Congress. On May 5th, psychologist Gregory Herick testified on the lack of rational justification for the ban before the House Armed Services Committee. Dr. Herick offered testimony on behalf of the American Psychological Association and National Organizations Responding to Discrimination in the Military (NORDSOM). SIECUS is a member of NORDSOM as well as the Campaign for Military Service, which are fighting for the repeal of this discriminatory policy through media messages, testimony, and liaisons established with the Department of Defense (DoD). Elsewhere, the DoD is finally moving to meet President Clinton's July time-frame for a plan to change the military policy on gays and lesbians. As part of this endeavor the Rand Corporation is conducting a study on the issues and directing a review of sexual conduct.

Colorado Measure

SIECUS has joined the boycott of Colorado to protest its anti-gay constitutional amendment and joined other organizations in signing onto a friend of the court brief to be filed in the Colorado Supreme Court challenging the constitutionality of the measure. Nine national organizations and eight prominent individuals advanced the argument that "Amendment 2 is not a public health measure," but is instead counterproductive to health goals.

Pro-Choice Legislation Update

Several national strategies to strengthen reproductive rights by codifying them into law are under way. A move to restore federal funding of abortion under Medicaid and other federal health programs has been advanced in the **Reproductive Health Equity Act** (RHEA). This legislation would negate the damaging effects of the Hyde Amendment passed in the late 1970s to deprive economically disadvantaged women from receiving financial assistance for safe abortion services. RHEA would also restore coverage of abortion funding for federal employees, indigent women in the District of Columbia, women in prisons, military dependents, and Native American women using Indian Health Services facilities. **Freedom of Choice Act** (S. 25 and H.R. 25), also known as FOCA, is another pro-choice initiative. FOCA intends to codify Roe

v. Wade into law, precluding states from passing legislation more restrictive than that which now exists and stopping further state-by-state intrusions on abortion rights.

A new effort, called the **Freedom of Access to Clinic Entrances Act** (FACE), proposes to come down hard on those who obstruct the delivery of health care with acts of violence and disturbances at women's clinics. The recent murder of Dr. David Gunn is the most extreme instance of such violence. Between 1977 and March 1993 the following assaults were reported nationwide: 322 clinic invasions, 441 cases of clinic vandalism, 53 attempted bombings or arson, 30 cases of stalking, 2 kidnappings, 872 hate letters and phone threats, 276 bomb threats, 556 clinic blockades.

These acts of violence are draining the resources of state and local law enforcement officials. SIECUS and many others are calling for the passage of a bill that would guarantee protection of the constitutionally-protected right to choose abortion services.

Title X Has Bipartisan Support

The House of Representatives has passed reauthorization of the Title X Family Planning Program (H.R. 670). The reauthorization was also approved by the Senate Labor and Human Resources Committee. As it stands, the measure would be renewed for two years, with a 20% increase in funding for the next year alone.

Strong bipartisan support for this bill added to the defeat of several potentially damaging amendments to Title X, including Representative Bliley's (R-VA) mandate to notify parents of minors seeking abortions at clinics receiving federal family planning funds.

Adolescent Health Gains Attention

On another front, Title XX, also known as the Adolescent Family Life Act, is going to be recrafted in order to make it more than just an abstinence-only program. A U.S. Department of Health and Human services proposal intends to use the existing program to pursue much needed comprehensive sexuality education, reproductive health, and parenting programs. SIECUS staff have worked with DHHS on the development of the proposal.

Another initiative includes the Comprehensive Youth Services Act (H.R. 1040) to provide local and state grants for school-based and school-linked adolescent health care and social services with reproductive components.

Sexuality Education Under Attack

Comprehensive sexuality education in the classroom remains controversial in many communities. Representative Tom Delay from East Texas went so far as to introduce a resolution in the U.S. Congress condemning SIECUS for its support of comprehensive sexuality education.

The resolution was only one of the reverberations from the discussions of a Texas State Advisory Committee about how to reduce the state's high teen pregnancy rate. The recommendations included a call for sexuality education for the state's children. The Texas Council for Family Values initiated a misinformation campaign that referred to SIECUS and a Texas state adolescent pregnancy advisory committee as "The Sex Pushers."

SIECUS eventually ended up being the subject of a non-binding resolution and was condemned for efforts to "impose a sexual agenda on the children of the United States." Representative Delay is the lone sponsor of the resolution, which carries warnings about "compulsory teaching....that homosexuality is equal to heterosexuality." He also alleged that SIECUS promotes "using both visual and graphic techniques of conventional and deviant sexuality." No action has been taken on this resolution and no serious consideration of it is thought likely.

Dealing with the Opposition

SIECUS released its *Community Action Kit* to provide an additional resource to support sexuality education. The kit was created for parents, teachers, community organizers and school administrators to use when encountering resistance to comprehensive sexuality education or when opposing attempts to establish fear-based sexuality curricula. SIECUS staff has identified 134 communities under attack and has provided in-depth technical assistance to over 70 communities. The kit is available for $29.95 and may be ordered through the SIECUS publication department.

Syndicated Sexuality Debate

Percy Ross, syndicated columnist, recently published a letter from a teenager concerned about sexuality education that does not enforce abstinence until marriage. However, millions of teenagers and their parents support comprehensive sexuality education that offers sound information, values human relationships, and supports responsible decision-making. If you are one such parent or know teenagers in support of comprehensive sexuality education, please write to Mr. Ross expressing your support of comprehensive sexuality education that includes abstinence as an option, but also provides information about contraceptives and condoms to prevent pregnancy and transmission of sexually transmitted diseases. Include your phone number and mail your letter to: Percy Ross, P.O. Box 39000, Minneapolis, MN 55439.

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