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SEXUALITY AND HEALTH CARE: AN INTIMATE RELATIONSHIP

Dore Hollander

Asks to name medical and health care issues that are related to sexuality, many people are likely to think of HIV and other diseases that are transmitted through sexual contact or of the need for appropriate and effective contraceptive methods. But as the contributors to this issue of the *SIECUS Report* demonstrate, medical, health care, and sexuality issues intersect on a variety of fronts.

At perhaps the most basic level, any condition—medical or psychological—that affects one's health status may affect one's self-image and, in turn, one's sexual desire, arousal, and functioning. Breast cancer is one such example; as Sarah Janosik and Cathy Schechter discuss in their article (page 6), some women may not be aware until after a mastectomy how high an "emotional investment" they have in their breasts. And, of course, some conditions may make certain sexual behaviors physically difficult or even impossible; in fact, Janosik and Schechter point out, as does Harvey Rosenstock in his medical checklist for sex therapists (page 11), even the treatment for some conditions can have adverse effects on sexual functioning. When an individual in an established relationship develops a condition that creates sexual problems, the stress on the partners, and on the relationship, may be enormous. For those whose condition emerges outside the context of a relationship, the problem may raise a new set of questions regarding whether and when to seek a new partner and how to approach a new relationship. In either case, the individual requires emotional support and appropriate care to treat both the sexual concern and the underlying problem.

To add to the difficulty of dealing with sexuality-related problems, many people are reluctant to raise these issues with physicians and other health professionals. As a result, the professionals involved may have to anticipate a patient's problems or questions and initiate discussion about them, as well as provide care. Professionals in a wide variety of health care specialties should be prepared to provide some aspect of that care, whether medical treatment, counseling, or referral to a source that is better able to address the problem. This requires not only training and technical expertise, but sensitivity on the part of health professionals; indeed, the effectiveness of certain types of treatment may depend on the quality of the relationship between the health professional and the patient.

And herein lies still another challenge: Health professionals must be aware, as Michael Plaut and Heidi Ginter write in their article (page 3), that "an effective clinical relationship requires a balance between closeness and separateness"—and they must know how to maintain that balance. Given the perceived power of physicians and other health professionals, and the vulnerability of patients—to some extent, all patients, but certainly those suffering with chronic or life-threatening conditions—health professionals must assume an active responsibility for keeping boundaries clear.

All of this places an unenviable burden on health care providers. Their ability to shoulder that burden depends to no small degree on adequate training throughout their careers: Education for medical and other preprofessional students, such as that described by Sandra Leiblum (page 8), must include components aimed at increasing their technical skills in managing sexuality-related problems; at heightening their awareness of when such problems may be present, even when patients avoid bringing them up; and at enhancing their ability to work with patients on such problems in a productive, sensitive, and comfortable manner. Formal continuing education for health professionals should expand on such training, taking into account new developments in relevant treatments. And individual practitioners should be open to incorporating new knowledge—about various health conditions and treatment options—into their approach.

Obtaining appropriate health care is often a daunting task, requiring, among other things, a feeling of empowerment. Individuals must understand their health status and know what kinds of care they can expect from various health professionals. They must be able to describe even their most intimate concerns and seek the help they need, despite the imbalance in the professional-patient relationship. Professionals, for their part, must create an environment in which patients will feel comfortable raising these concerns with them. We hope with this issue of the *SIECUS Report* to help health professionals become aware of ways in which they can empower their patients to seek and participate in adequate, appropriate care, regardless of how sensitive the matters involved.

SEXUAL BOUNDARIES BETWEEN HEALTH PROFESSIONALS AND CLIENTS: A BLUEPRINT FOR EDUCATION

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The last twenty years have witnessed an increasing concern with boundary violations by health professionals. Sexual exploitation is considered one of the most serious ethical violations in the mental health professions and is of growing concern in other health professions, as well. Sexual violations can harm victims and their families, the careers and relationships of offenders, and the image of the health professions, especially when the professions are perceived as minimizing the seriousness of the problem.¹

THE NEED FOR EDUCATION

Professionals' attention to this problem has focused mainly on tighter ethical standards and sanctions for offenders, although these areas still deserve greater attention.² It has also become increasingly apparent that educational programs are not addressing the issue very well.³ For example, in a study of 314 psychiatric residents in Canada, only 9 percent reported receiving "thorough" training about patient-therapist sexual relations; 21 percent had had no such education at all.⁴ Most teaching in this area in U.S. and Canadian psychiatric residency programs has begun within the last ten years; the content, format, and time devoted to it may vary.

Attempts to determine the extent of education about professional-client boundaries have generally involved retrospective surveys of professionals who have completed their training and, therefore, have covered a wide interval of professional practice. We recently asked 126 students entering their fourth year of medical school—one in each medical school in the United States and Canada—about their educational experience in this area. Of the thirty students who responded, 67 percent reported that their schools provide education related to professional-client boundaries as required or elective courses. Among those whose schools include such teaching, 77 percent consider this instruction "a good basis for understanding professional-client boundaries." Overall, 93 percent of the respondents feel that this area should be a part of the required medical curriculum.

Although these results are encouraging, it is clear that many schools either do not cover such material or teach it in

a way that is not maximally effective. For example, several students suggested that the discussion of individual cases in small groups would be more effective than lecture presentations, or that the issue should be revisited during clinical phases of their education. Some students realized the need to address the balance between supportive and harmful expressions of intimacy, or were sensitive to the dilemmas posed in closed systems, such as rural settings. The need for attention to student-teacher boundaries also emerged as an issue. Meanwhile, some students are resistant to such education, believing that boundary issues are just a matter of common sense, or that these issues should have been addressed "at home before medical school." One student insisted that "all that is needed is a review of laws and ordinances."

AREAS OF NEED AND RECENT ADVANCES

Education in professional-client boundaries is important in four settings: professional education or residency training, continuing education for individual practitioners, institutional programs (for mental health departments, hospitals, clinics, and so forth), and educational rehabilitation programs for offenders. More specialized education is in order for professionals who sit on licensing boards, ethics committees, or credentialing committees, who must often consider cases against colleagues alleged to have violated appropriate provider-client boundaries. Most of the established programs are aimed at professionals in mental health and related fields, although the focus is beginning to broaden.

Disciplinary actions relating to professional-client boundary violations often include the requirement that the offender enroll in a rehabilitation program that contains an educational component.⁵ Such a requirement, while well intended, does not ensure either that the course includes subject matter relevant to the offense or that the professional has mastered relevant concepts. One of the most effective ways to assure that effective learning has taken place is to require that the offender undergo a board-sponsored and board-monitored tutorial designed to meet specific objectives.

A POSITIVE APPROACH— THE NEED FOR BOUNDARIES

The resistance on the part of students mentioned earlier is typical in situations where the students do not understand why it is in the patient's best interests to maintain professional-client boundaries. The reasons are often subtle, vary somewhat with the situation at hand, and involve both non-sexual and sexual issues. Once this is understood, it is difficult to defend the position that professional standards merely reflect "common sense" or that they necessarily extend from moral standards presumably taught in the home.

An appreciation of appropriate boundaries must begin with the understanding that a certain level of closeness may be desirable for clinical effectiveness. The clinician's warmth, caring, and appropriate touch are often integral to effective patient care. At the same time, excessive or inappropriate closeness may compromise the professional's objectivity, confuse the client as to what appropriate boundaries are, and prevent the client from achieving the independence from the professional that is the ultimate goal of the helping relationship. Thus, an effective clinical relationship requires a balance between closeness and separateness.⁶ That balance may differ in various professional settings. For example, a radiologist, dentist, psychologist, physical therapist, gynecologist, and clinical supervisor may correctly perceive their boundary restrictions somewhat differently.

Students must also learn that the dependence of a client on a professional and the trust that is a necessary part of their relationship naturally impart a certain power to the professional that he or she has the responsibility not to abuse, sexually or otherwise.⁷ While either party may experience sexual feelings, the professional is always the one responsible for maintaining boundaries. The power differential inherent in such relationships renders the patient vulnerable and unable to participate in such a relationship as a truly consenting person. Furthermore, the client's dependency may persist beyond the termination of a professional relationship, and the professional must be sensitive to that possibility and know how to address it.

Another point that students must understand is that sexual attraction experienced by either the client or the clinician may be symbolic, rather than reflecting real feelings. It is the professional's responsibility to consider that an apparent attraction may reflect unconscious representations of other relationships in the life of either party.⁸

Sexual contact is typically considered the most extreme and most traumatic form of boundary violation. However, struggling with some of the more subtle, nonsexual boundary issues may help students understand the importance and complexities of boundary issues.⁹ These issues are many and varied. For example: Under what conditions may a professional accept gifts or social invitations? To what extent are

dual relationships (for example, employment of or socializing with a client) acceptable? To what extent is touch between professional and client acceptable? Is it acceptable for the professional to disclose personal information to the client? Are particular kinds of personal disclosure more or less appropriate? How does one manage the problem of dual relationships in relatively closed systems, such as military settings, rural areas, or hospitals? How are these considerations translated into ethical and legal standards for professional behavior? Because boundary violations typically involve male offenders exploiting females, one must also consider the role of cultural factors, such as men's attitudes toward women and how men relate to women in professional settings. The use of clinical vignettes, sessions with offenders or persons who have been sexually exploited, or discussion about personal experiences with professional-client boundaries in small group sessions can be invaluable in exploring these issues.

A critically important aspect of this learning process is the modeling that students experience in their own relationships with their teachers, supervisors, and mentors.¹⁰ The boundaries between teachers and students are generally looser than those expected between provider and client in a clinical situation, as a certain level of friendship and socializing is a constructive part of the mentoring relationship. Even here, however, the need for the teacher to evaluate and to guide the student requires a certain level of distance and objectivity. The teacher's ability to maintain that balance can help students prepare for their own roles as clinicians or teachers.

PREVENTING AND ADDRESSING BOUNDARY VIOLATIONS

A knowledge of what is necessary to prevent boundary violations first requires an understanding of the dynamics of boundary violations. As mentioned above, an apparent sexual attraction may be an unconscious representation of a deeper emotional need. When emotional involvement between a professional and a client occurs, the professional often rationalizes his or her behavior; the client, who may have a history of being sexually exploited, often exhibits self-blame or ambivalence.

Given these and other characteristic patterns, there are warning signs that the professional can learn to identify, such as consistently looking forward to a certain client's arrival, fantasizing at length about a specific client, or vulnerability related to a loss in the professional's own life. By seeking consultation when experiencing any of these warning signs, professionals can prevent matters from getting out of hand.

Students can also learn how to respond appropriately to clients who make sexual advances toward them.¹¹ Such advances are often related to the symbolic significance of the provider as caregiver or the stimulus deprivation that often accompanies the institutional environment. People who have previously been exploited may equate a sexual

response from their provider as a sign of love and acceptance. A provider's sexual response to a client's advances only prolongs the client's dependency, provides a false sense of security, and can lead to feelings of betrayal when the relationship ends. For these reasons, the professional must learn to offer emotional support and empathy yet maintain appropriate professional distance. Persistence of sexual advances on the part of the client may require more direct confrontation or appropriate referral.

Finally, students need to learn about the various roles they are likely to play in cases involving allegations of boundary violations by their colleagues.¹² What would be their role as a subsequent therapist to a patient who has been exploited?¹³ To what support resources can one refer a patient who has been sexually exploited? How does one conduct an effective evaluation of an alleged offender? What kinds of rehabilitation programs are most effective, and in what cases are they not effective at all?

CONCLUSION

Professional-client boundary violations are among the most serious ethical infractions in the health professions because of the damage they inflict on their victims. Yet, health professionals and those who educate them have done relatively little to help their colleagues and students understand either the importance of appropriate boundaries or the factors that put professionals at risk for boundary violations. Coverage of material in this area not only must be expanded, but should be institutionalized through inclusion in examinations for licensure or certification or as a criterion for institutional accreditation. Further development of a broad range of case materials and videotaped vignettes would also help to ensure coverage of critical aspects of the problem. This is an aspect of professional education that students and their potential patients and clients need and deserve.

AUTHORS' NOTE

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SEXUAL WELLNESS AND BREAST CANCER

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Elaine, a forty-year-old married woman with two children, discovered a lump in her breast at her annual examination. A biopsy led to the discovery of cancer in both breasts, and she had a bilateral mastectomy, followed by chemotherapy and radiation. At the time of the surgery, she decided to have breast reconstruction.

After completion of her treatment, Elaine attempted to renew her sexual relationship with her husband, a patient and kind man with whom she had always had a good relationship. Now, to her dismay, she found she no longer had the same sexual desire. As a result of chemotherapy, she had gone into early menopause, so her vaginal wall had thinned and lubricated poorly, causing pain during intercourse. Surprisingly, her breasts were now totally numb. Prior to her surgery, she had not realized how much she relied on her breasts to arouse her.

Elaine became estranged from her husband and sank into depression. After two years, she sought help from a sex therapist because she wanted to resolve the issues surrounding her sexuality after breast cancer. Only then did she begin exploring her sexuality in her “new” body, researching the sexuality-related side effects of her treatment, and making some decisions about her treatment that would affect her sexual functioning.

Elaine is a composite of many women after breast cancer. Unfortunately, many health care providers miss a diagnosis of sexual dysfunction after breast cancer. Why? Partially because they assume that nothing can be done—that this is just a fact of cancer, and that “women should be glad simply to be alive.” Also, many providers are uncomfortable discussing this issue, or do not have the time, setting, or information to help. The missed opportunities would not occur, however, if the process of identifying, evaluating, and remedying psychosexual dysfunction following breast cancer became an integral part of care.

What professionals should be involved? Primarily, health care professionals who treat patients for extended periods of time after surgery need to be knowledgeable about sexual issues after breast cancer. These include oncologists, registered nurses, plastic surgeons, primary care physicians, psychotherapists, physical therapists, and cancer survivors’ support group leaders.

When is the best time to address sexuality? At the initial diagnosis of breast cancer, most women are in shock; survival is their primary focus. The crisis period is a time of life-shattering decisions, and it can be a difficult time to talk about sexual intimacy. While this is clearly not the time to begin to solve a problem that patients do not yet have, clinicians can begin to suggest—particularly to women who will listen—what may come. Specialists who continue to see patients after the initial crisis will have more opportunities to help with problems that arise.

After surgery, and during the treatment or recovery period, providers need to integrate an assessment of sexual function in the overall health picture. Most women going through this process will have questions and concerns about sexuality, but many may be reluctant to ask questions or discuss so personal an issue.

What are the risk factors for sexual dysfunction?

Health professionals should look for the following characteristics, which may put women who have had breast cancer at risk for sexual dysfunction:

- being young and having a high emotional investment in their breasts;
- not having had the number of children they had hoped for, or considering childbearing a major life goal and strong component of a marital relationship;
- having been sexually abused;
- not having had the treatment of their choice;
- having few areas of gratification or sources of self-esteem outside their intimate relationships;
- having a history of substance abuse;
- having a history of psychiatric morbidity;
- being single; and
- having a focus on others rather than a strong sense of self.

Education is critical. Professionals responsible for promoting health must acknowledge that sexuality is a vital part of life, and that to ignore sexuality-related issues in the treatment of disease is to adhere to a medical practice that does not treat the “whole person.” Rounding out treatment

and addressing the whole person entails weaving an organized educational effort into the overall treatment plan. Whether providers set aside time during a follow-up visit or work in tandem with a nurse, therapist, or other health educator, they must be willing to address these issues with all patients.

The majority of women do not experience long-term sexual maladjustment following breast cancer surgery. In the short run, 10 percent of women who have a benign biopsy have some sexual problems; 30–40 percent of women who have a modified radical mastectomy experience sexual dysfunction. Studies comparing women who have had a mastectomy with those who have had a lumpectomy show that in the short run, the latter have less psychiatric morbidity.¹ In either event, it is highly likely that with acknowledgment by the health care team and a concerted effort at patient education, there are fewer incidences of depression and sexual dysfunction, and fewer marital problems.

A woman's sexual orientation and marital status may also affect her adjustment to life following breast cancer surgery, and these issues must be addressed in the education process. Women without partners will have to decide if they want to pursue new relationships, and how to bring up their surgery when they do. Lesbians are often reluctant to discuss their sexuality in support groups, or even to their care providers; they need encouragement through inclusive language and their partners' participation in their treatment program. For married women, roles often change when men become caregivers during treatment; as roles change, relationships may likewise change.

What questions should the health professional consider in assessing the patient? Assessment of patients' sexual functioning should go on throughout treatment and recovery. It is imperative for the health professional to consider the type of treatment a woman has undergone, as well as to ask specific questions about sexual functioning.

Different treatments may have different effects on a woman's sexual experiences. Chemotherapy often brings about menopause, and the results are lost vaginal lubrication, thinning of the vaginal wall, and pain during intercourse or lack of sexual interest because of decreased hormone production. Tamoxifen is a treatment option for some women, but its side effects are much like the effects of menopause. However, the drug's effects disappear when treatment is terminated.

The clinician should be prepared to open the discussion of sexuality-related issues, particularly with women who may find it difficult to speak about this subject. The following questions may provide a good start, but the clinician should also follow them up with more specific questions:

- In general, how are you responding to treatment?
- Have you experienced any physical changes that are bothering you?
- Have you experienced any changes in your sexual desire, arousal, or ability to achieve orgasm?
- How have these changes affected your relationship?

Because some patients will be uncomfortable talking about these matters, it is absolutely crucial for the health professional to find "teachable moments." Some of the most teachable moments come when people seek help for themselves, as in support groups and one-to-one counseling. However, because most women do not seek support groups or counseling, the most teachable moments may come when they visit the oncologist, plastic surgeon, or treatment center. In those instances, it is helpful to provide patients with comprehensive educational materials. Whenever staff can be trained to have a special sensitivity to these issues, so much the better.

What can survivors expect? The long-range prognosis for the typical survivor, like Elaine, can be very hopeful. Through therapy, medication management, appropriate doses of testosterone, and a path of self-discovery in their new bodies, such patients can adjust to the experience of being a breast cancer survivor. Their partners can be encouraged to address the issue, and may grow through the experience. Couples may realize that while their sexual relationship is not what it used to be, "different" is not always bad. In many cases, couples find themselves becoming more intimate and playful, and are able to discover new ways to enjoy each other.

Other women are not as lucky. Those who have a type of cancer that is thought to be aggravated by hormone therapy may not be able to tolerate medications to help reduce the symptoms of menopause and such possible effects as weight gain, depression, anxiety, and impaired sexual functioning. For them, education is even more critical, because lack of knowledge makes these changes even more frightening, discouraging, and depressing.

Sexuality is a crucial quality of life issue. All women have sexual concerns. To acknowledge this facet of treatment promotes treatment of the whole person, and thereby assures better quality and more well-rounded care.

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TEACHING SEXUALITY TO MEDICAL STUDENTS: CHALLENGES AND OBSERVATIONS

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Sexuality is a health matter. Patients of all ages have sexuality-related questions and concerns, and often it is their physician to whom they look for answers. While professionals in a variety of fields consider themselves experts in this area, concerns about sexual normality, pathology, and function are still regarded as the province of physicians. Questions about the sexuality-related side effects of medications and oral contraceptives are widespread, as are worries about the prevention and treatment of sexually transmitted diseases (STDs), the consequences of sexual or physical abuse, the dangers of various sexual practices, and the remediation of sexual difficulties. If left unaddressed and unanswered, such concerns may cause anxiety and even physical discomfort. It is imperative that physicians of all specialties be comfortable in—and capable of—dealing with the sexuality-related issues and anxieties of their patients.

Yet, most physicians are inadequately prepared to assume the role of sexuality educators. Some are uninformed, intolerant, and homophobic. Some are insensitive to the cultural and religious beliefs of the populations they work with and are unable to provide relevant information in appropriate language. Many are uncomfortable initiating conversations about sexually sensitive behaviors. Without education and training, even the most highly skilled and motivated physicians will be ineffective in reaching adolescents; individuals who engage in risky behaviors; or, for that matter, any individual whose background, beliefs, or sexual orientation differs significantly from their own.

It is for this reason that teaching medical students about sexuality is so essential. Robert Wood Johnson Medical School in Piscataway, New Jersey, has been offering a course in sexuality for the last twenty years. The course has evolved to reflect changing social realities, as well as changes in medical students and medical school education generally, and appears to be meeting both the professional and the personal needs of students.

COURSE DESCRIPTION

The sexuality course at Robert Wood Johnson Medical School is a required course that is offered jointly by the department of psychiatry, the department of environmental and community medicine, and the Graduate School of Public Health to second-year medical students and graduate students in related disciplines (including nursing, psycholo-

gy, social work, physician assistant training, nurse-midwifery, theology, and public health). Faculty from several departments within the medical school, as well as guest faculty from other institutions, participate in the forty-hour, five-day course. A small faculty-student committee is responsible for planning the program.

Teaching methods include lectures, films, panel discussions, and small group discussions. A handbook of readings is provided, and optional workshops are offered in the evening on such topics as sexuality and religion or balancing the demands of a medical career and a personal life.

The small groups, which meet for fifteen hours, give students the opportunity to discuss the sensitive and, at times, provocative material covered during the formal presentations, as well as to role-play clinical interactions, including taking a sexual history. Students generally regard the small group discussions as the most powerful and memorable of the week's activities.

In recent years, the course has increasingly incorporated panel discussions rather than lectures. Having panelists speak from their experience, rather than as "experts," seems to enhance the credibility of the speakers and encourages a more meaningful exchange with the students. The question-and-answer period that follows all presentations is usually lively (and often too short).

COURSE OBJECTIVES

The course has two major objectives. First, it aims to assist students in identifying and clarifying their values and beliefs regarding different sexual orientations and behaviors. This includes creating an understanding and respect for the differences in sexual norms and mores across cultures, religious and ethnic groups, and life stages. Coursework is designed to encourage students to explore whether overt or covert homophobic, sexist, racist, or ageist attitudes are interfering with their interactions with patients.

Second, the course is intended to provide sound information concerning basic content areas. Although the course content changes from year to year, the following topics are typically covered:

- male and female sexual anatomy, physiology, and response;
- gender differences and similarities in sexuality;
- cross-cultural diversity in sexuality;

- common sexual concerns that need to be addressed in various medical specialties (for example, gynecology, urology, pediatrics, endocrinology);
- sexual orientation;
- psychosexual issues associated with HIV/AIDS and other STDs;
- sexuality and aging;
- sexuality and disability;
- sexual coercion;
- interviewing patients about sexuality-related issues;
- love, sexuality, and relationships; and
- how to deal with sexual attraction between physician and patient.

Students can get the basic facts about almost any aspect of sexuality from books. The emphasis in this course is on increasing self-awareness—helping students become more respectful, tolerant, knowledgeable, and sensitive health care providers. Therefore, while attendance at all small group sessions is required in order to obtain a passing grade (students who miss any of the discussion groups are required to write a paper or review relevant research), no formal examination is given.

THE CHALLENGES OF MEDICAL SCHOOL SEXUALITY EDUCATION

Medical students are an increasingly diverse group. While the gender ratio between the sexes has been markedly reduced over the last decade (the proportion of female students now approximately equals that of male students), enormous differences remain in students' religiosity and religious affiliation, liberal versus conservative upbringing, ethnic background, sexual experience, and comfort with and exposure to sexuality education. For instance, some religiously observant students are extremely uneasy about viewing any sexually explicit material or condoning any relationship other than a heterosexually monogamous one. A week devoted to sexuality education with mixed-gender small discussion groups may be quite uncomfortable for them. For other students, who have grown up in a culturally permissive milieu with considerable exposure to sexual expression and sexuality education, the "expressive, experiential" learning atmosphere that courses often strive for seems forced and unnecessary. These students have been bombarded by explicit images in music videos, magazines, and popular films. Nothing shocks, offends, or threatens them (or so they say), and they protest the idea of spending fifteen hours in small group discussions about sexuality. Somehow, a course dealing with sexuality must be designed to meet the needs of the entire continuum of students—from those who are sexually conservative and easily offended to those who are sexually

sophisticated and even jaded. Students who find any presentation upsetting or offensive are excused from attendance; few avail themselves of this option.

ROLE OF EXPLICIT FILMS

The sexual attitude reassessment (SAR) format, popular in the late 1970s and early 1980s, relied largely on sexually explicit films as a way of desensitizing students to dealing with such material and preparing them to talk about their feelings. Today, the SAR approach is less relevant, and course directors must be prepared to offer a clear rationale for using precious curriculum time to show films depicting sexual behavior. Rather than including films for their explicitness alone, courses should use videos dealing with topics that have not often received attention in formal education settings, such as child sexual abuse and sex therapy interventions.

In certain instances, however, films showing couples engaging in sexual activity may be justified. For instance, many students have difficulty imagining the sexual behavior of men and women with various injuries or disabilities; a film that incorporates explicit sexual sequences interspersed with discussion by individuals with disabilities may be a useful teaching aid. Similarly, although most students say they are not homophobic, their reactions to viewing sexually explicit films involving gay men and lesbians are often negative; screenings of such videos may lead to lively and constructive discussions in the small groups as students confront their emotional, rather than intellectual, responses to this material.

TAKING A SEXUAL HISTORY

One important aspect of medical school sexuality education is teaching students to take a sexual history and enabling them to feel comfortable doing so, irrespective of their patients' age or health. Such teaching takes time and, ideally, is conducted within a small enough group so that each student has the opportunity to participate. Some medical schools effectively use trained actors for this purpose, other schools use videos, and still others use role-playing.

The Robert Wood Johnson program uses role-playing. Each student has the opportunity to role-play both the patient and the physician, while the remaining students in the group observe the interaction. In discussions after each role-play, the students evaluate the "physician's" comfort and interviewing style, taking into consideration both the verbal and the non-verbal messages the student communicated in the exercise.

Given the importance of inquiry in sexuality-related prevention and education efforts, this activity may warrant more time than it currently gets in most medical schools, including Robert Wood Johnson. While no research has been done on the effectiveness of role-playing, anecdotal evidence suggests that students apply the skills emphasized in these sessions in their medical practice.

SEXUAL ATTRACTION BETWEEN HEALTH CARE PROFESSIONALS AND PATIENTS

While sexuality-related training in medical school often focuses on "seductive patients," too little time is spent on "seductive doctors." The Robert Wood Johnson course encourages physicians and other health care professionals to address the issue of their attraction to various patients. Instructors make it clear that clinical professionals are likely to feel sexually attracted to some patients some of the time, but remind students of their responsibility to act professionally. For instance, speakers acknowledge that sometimes, physicians experience unexpected sexual reactions in response to seeing a patient disrobe, and discuss the most sensitive way of handling these spontaneous and often embarrassing reactions. They also cover the issue of power in professional relationships and how easily it can be misused or abused.

EVALUATION OF TEACHING PROGRAMS

Evaluation of teaching programs in medical school sexuality education courses is difficult. While examinations can be given that assess mastery of the didactic content of the course, the true measure of a program's efficacy is an increase in students' sexual and self-awareness, and their greater comfort and skill in routinely conducting sexual inquiry and making appropriate referrals for sexual counseling in their clinical practice. Unfortunately, these changes cannot be realistically assessed via a written examination.

The program at Robert Wood Johnson Medical School

has tended to rely on student ratings of each of the week's presentations, as well as more extensive qualitative feedback at the conclusion of the program. Students are specifically asked how the program affected them and how it can be improved; the majority strongly endorse the continuation of the course and cite it as a "personal eye-opener."

In light of the need to cover so many subjects in medical school education and the vying of each department for more curriculum hours, it seems certain that in the future, teaching programs in sexuality will be expected to justify or defend the curriculum hours they absorb. In preparation for this eventuality, empirical research documenting the transfer of skills and assessing attitude change is important. Developing innovative approaches to conducting this type of assessment is a challenge.

CONCLUSION

Sexuality education is an essential part of medical school education, one with unique challenges and rewards. Not only must students learn an ever-increasing amount of material during medical school, they must learn to become cognizant of—and to deal with—their prejudices and misconceptions concerning the wide variety of patients they will treat. With respect to sexuality, they must be aware of their personal values and beliefs, and how these may affect their patient care. Awareness of sexual attraction between clinicians and patients is essential, since health care providers have unique physical access to their patients by virtue of the physical examination, as well as psychological "access" by virtue of the power and prestige associated with their profession.

CALL FOR SUBMISSIONS

Following is a schedule of themes for the coming volume of the *SIECUS Report* (volume 24). If you are interested in submitting an article, a related book or video review, or a critical analysis of the issues, send a draft manuscript, double-spaced, to the Editor, *SIECUS Report*, 130 West 42nd Street, Suite 350, New York, NY 10036. (Detailed instructions for authors appear on the inside back cover of this issue.)

Gender Issues in Sexuality Education

October/November 1995

Deadline for final copy: August 1, 1995

Consenting Adults: Men, Women, and Sexual Relations

December 1995/January 1996

Deadline for final copy: October 2, 1995

Sexuality Education around the World

February/March 1996

Deadline for final copy: December 1, 1995

Sexuality in the Media

April/May 1996

Deadline for final copy: February 1, 1996

New Resources and Technology in Sexuality Education

June/July 1996

Deadline for final copy: April 1, 1996

The Politics of Sexuality Education: 1996

August/September 1996

Deadline for final copy: June 3, 1996

MEDICAL CONSIDERATIONS FOR SUCCESSFUL SEX THERAPY

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Most sexual complaints for which men and women seek therapy derive from an interpersonal or situational context, and professionals without a medical background can provide effective treatment. However, it is important for therapists to discern whether any medical factors underlie the conditions for which patients seek treatment. The earlier the therapist can make this determination, the sooner the treatment can be effective and the better the outcome.

During the initial assessment of any patient, a therapist might consider using a checklist containing questions designed to identify medical conditions that may be a factor in the presenting complaint. The following checklist includes a medical rationale for each question to enable the therapist to make a complete assessment.

(1) When was the patient's last complete physical examination? Did this include detailed medical history and laboratory testing? Was a genital or pelvic examination included? In some cases, the successful treatment of a disease or medical disorder may reduce or obviate the need for sex therapy. For example, hypothyroidism can cause lethargy and loss of sexual desire; reversing the thyroid condition with hormonal replacement usually eliminates these symptoms. Pelvic inflammatory disease can result in sexual abstinence due to pain and discharge; often, antibiotics are curative, and once rid of the infection, patients feel comfortable resuming sexual relations.

(2) Does the patient or a family member have a history of medical illness? Specifically, is there a history of vascular diseases, hypertension, or diabetes? Circulatory problems may impair function in affected organs, such as the genitals. The medical treatment for hypertension can cause diminished interest in sexual activity and difficulties with sexual functioning. Diabetes is one of the main causes of impotence.

In each case, treatment of the underlying condition may alleviate sexual dysfunction. Circulatory problems may respond to medications (vasodilators) or surgical procedures, such as bypass. For hypertension, a variety of medications are available, and the clinician may be able to identify one that

will be effective yet not have adverse side effects. Diabetes, depending on the severity, may be controlled through diet and medication, resulting in overall improvement; in other cases, however, such interventions as penile injections or surgical insertion of a penile prosthesis may be needed.

(3) Does the patient or a family member have a history of psychiatric illness? Some sexual dysfunctions may be secondary to the disordered thinking associated with psychotic disorders, such as schizophrenia, or psychotic depression. For example, delusional thoughts may lead to unrealistic sexual demands or even to genital self-mutilation. Treatment of the underlying psychiatric disorder is necessary before sex therapy can take place. In some instances, successful treatment of the psychotic disorder will restore normative functioning.

(4) Is the patient taking any prescription medications? For how long has he or she been taking each medication? What is the dosage of each drug, and has it changed recently? Certain medications or combinations of medications can induce a variety of sexual dysfunctions. Some popular antidepressants—including fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil)—may diminish sexual interest or delay orgasm. Antihypertensive drugs may result in erectile dysfunction. Benzodiazepines such as alprazolam (Xanax) and diazepam (Valium) can occasionally cause rage reactions, paranoid thinking, or depressive symptoms, all of which may impair sexual functioning. Anabolic steroids,

which some athletes use, can produce uncontrolled aggression, mania, and psychotic thinking. Narcotics, while providing pain relief, may also be associated with such untoward effects as dysphoria (unpleasant mood), depression, paranoia, and psychosis. Some nonsteroidal anti-inflammatory drugs can produce side effects identical to the effects of narcotics.

Treatment for drug-induced sexual dysfunctions and untoward emotional reactions usually consists of identifying the offending agent and substituting a similar-acting medication (from either the same family of drugs or a different chemical family). Illicit use of anabolic steroids usu-

"Being fully informed of each patient's medical history and condition will make a therapist... more effective in serving the fundamental needs of patients."

ally requires counseling along with the cessation of use of these drugs.

(5) Is the patient taking any illicit drugs? Does the patient abuse alcohol? Illicit drug and alcohol use may cause impotence or lack of desire. In addition, the abuse of drugs may cause disordered thinking, including confusion and poor reality testing. Patients may have to undergo detoxification before sex therapy can be effective.

(6) Does the patient have a genetic disorder that is associated with a compromised self-image with implications for sexual functioning? For example, one of the most common inherited sex chromosomal abnormalities is Klinefelter's syndrome, which is associated with sterility and undescended testicles; often, the testicles have to be surgically removed to prevent testicular cancer. Although patients with this disorder can have intercourse with the help of male hormone supplements, the tremendous adjustments they have to make at critical developmental periods requires that a therapist be both knowledgeable about and comfortable with the

natural history of this disease. It is particularly valuable for a therapist and patient to form a trusting relationship before testicular implants have to be considered.

(7) Is the patient sufficiently comfortable with his or her physician to openly discuss sexual concerns? All too often, patients are not comfortable discussing their sexual problems with their physicians, who then assume that no such sexual problems are present. Sex therapists can become powerful ombudsmen for their patients by encouraging and facilitating communication between the patient and the physician regarding sexual desire and functioning.

The checklist presents basic principles to help clinicians serve patients best by avoiding errors of both omission and commission. It can be modified according to the needs of the particular populations served. Being fully informed of each patient's medical history and condition will make a therapist able to recognize his or her limitations, less vulnerable to complaints and legal actions of dissatisfied patients, and more effective in serving the fundamental needs of patients.

NEW PUBLICATIONS OF NOTE

- The Social Science Research Council's report *Sexuality Research in the United States: An Assessment of the Social and Behavioral Sciences* provides an overview of the origins and history of sexuality research, discusses gaps in research and priorities for a future research agenda, and identifies the obstacles to research. Topics covered include HIV/AIDS, sexual orientation, adolescent sexuality, and sexual coercion; research issues addressed are those relating to methodology, design, and implementation. To order, contact the Social Science Research Council, 605 Third Avenue, New York, NY 10158; 212-661-0280.
- The Alan Guttmacher Institute's study *The Politics of Blame: Family Planning, Abortion and the Poor* examines the reproductive behavior of poor and low-income women, and assesses the consequences—for these women and for society—of denying them Medicaid or other insurance coverage for abortions. The report also examines the financial implications for the states and the federal government of restoring public financing of abortions for poor women and discusses the likelihood that current welfare reform proposals will affect adolescent pregnancy and out-of-wedlock childbearing. To order, contact The Alan Guttmacher Institute, 120 Wall Street, New York, NY 10005; 212-248-1111.

SEXUALITY AND THE 104TH CONGRESS: THE FIRST HUNDRED DAYS

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While the public counted down the final days of the much ballyhooed "Contract with America," the hundred-day legislative agenda put forth by Republican members of the House of Representatives, Congress was moving forward with legislation (some of it in the Contract) related to sexuality. Out of the headlines and the public's eye, much of this action moved toward obstructing the flow of information about sexuality.

THE MEDIA STAR

The Personal Responsibility Act was the legislation touching on sexuality that grabbed the headlines. But the reason that this 400-page welfare reform component of the Contract, which the House passed by a vote of 234-199 on March 24, gained notice was not that it prohibits cash assistance to unwed teenage mothers and denies additional benefits for children born to women already on welfare. The reason was the acrimonious debate over the Act's \$66 billion cuts in federal aid to poor families and its ceding to the states control of forty public assistance programs.

President Clinton has threatened a veto because he feels the Act would "punish children" by cutting off benefits to unwed teenage mothers and does not provide enough training and child care to welfare recipients.¹ He has, however, not objected to the legislation's omission of sexuality education or other pregnancy prevention services.

BEHIND THE HEADLINES

Meanwhile, legislation dealing head-on with sexuality issues was largely ignored by the media and may even have escaped the attention of advocates of these issues.

Sexual Behavior and Attitude Research. In one early action, the 104th Congress indicated that sexual behavior and attitude research—a longtime subject of controversy in Congress—would again come under scrutiny.

Congressional battles over sexual behavior and attitude research date from the Kinsey study in the 1950s. In 1989

and 1990, two scientifically sophisticated behavioral studies—the American Teenage Study (ATS) and the Survey of Health and AIDS Risk Prevalence (SHARP)—were stopped by conservative members of Congress who believed that these studies by "liberal" sexuality researchers would create a "sexually permissive environment" and "promote an anti-family, sexually decadent, gay lifestyle."² With respect to the teenage survey, opponents claimed that merely asking a question about sexuality would breach family privacy and promote sexual activity.³ In 1993, the reauthorization bill for the National Institutes of Health (NIH) permanently banned federal funding for the ATS and SHARP studies, although it allowed NIH to fund sexual behavior research that was directly linked to disease prevention. That same 1993 bill attempted to put all funds earmarked for sexual behavior research into the account for the chastity-promoting Adolescent Family Life Act.⁴ Notably, this amendment was passed by the Senate and failed in the House. (It was dropped in the House-Senate conference.)

In 1995, the House restricted sexual behavior research. On April 4, by a vote of 418-7, it passed the Family Privacy Protection Act, which had once been included in the Contract with America. This legislation requires that researchers conducting federally funded studies obtain the written consent of a minor's parent or guardian before asking a minor about any of the following: "(1) parental political affiliation or beliefs; (2) mental or psychological problems; (3) sexual behavior or attitudes; (4) illegal, antisocial or self-incriminating behavior; (5) appraisals of the individuals with whom the minor has a familial relationship; (6) relationships that are legally recognized as privileged, including those with lawyers, physicians, and members of the clergy; and (7) religious affiliations or beliefs."

The Act does offer general exceptions, such as inquiry made for the purpose of a criminal investigation or adjudication; pursuant to a good faith concern for the health, safety, and welfare of an individual minor; to facilitate administration of federal immigration, tax, or customs laws; and to

determine eligibility for financial assistance. It also provides exclusions for academic performance tests and for programs and activities that are subject to the General Education Provisions Act, which governs classroom activities.

Passage of this bill was a disappointment to advocates for behavioral and social science research. Such advocates were more pleased with the version of the bill that came to the House floor from the Government Reform and Oversight Committee, which did not require prior written parental consent. Rep. Mark Souder (R.-IN) offered an amendment that reinserted the requirement for *written* parental consent. Basing his remarks on a questionnaire developed and distributed by a school newspaper his two children received, he argued that it is reprehensible to ask high school students such questions as the following without their parents' written consent: "Do you know what gonorrhea, genital warts, herpes or syphilis are?" "Are you going to wait to have sex until you are married?" "Are you a virgin?"

While absolutely supportive of the right of parents to be informed about any research involving their minor children and to deny permission for their children's participation, behavioral and social science research advocates stressed that requiring written consent will have an adverse effect on the research. Advocates pointed to research documenting that a requirement for written consent may undermine efforts to include minors from disadvantaged backgrounds, whose parents are often too busy to return the consent form. Rep. Cardiss Collins (D.-IL), ranking minority member of the Government Reform and Oversight Committee, emphasized that such a requirement is unnecessary because federal regulations protect the interests of parents and their minor children; that such provisions would add to schools' administrative costs and burdens because schools could not divulge the contact information to the researchers; and that repeated follow-up regarding unreturned consent forms would itself be intrusive. Representative Collins also stressed that parental consent requirements on such matters usually are, and should remain, the purview of local communities.⁵ Despite these arguments and the Committee's previous unanimous support for the original language, the Souder amendment was adopted by a vote of 379-46.

While the Souder amendment focused on parental consent for research involving adolescents, Rep. Robert Dornan (R.-CA) introduced an amendment to the Family Privacy Protection Act clearly meant to curtail sexual behavior and attitude research overall. Representative Dornan moved to prohibit federal funding of all sexual

behavior surveys, arguing that the federal government has no business subsidizing this research. "We have been through this for several years now," Dornan said. "First, it was the adult sex survey in 1989. Then one year later we had to put a stop to a sex survey for teenagers and pre-teens...." Furthermore, he said, the Centers for Disease Control and Prevention "just keep pressing for more and more information in areas that remain sensitive without influencing at all what the specific six Centers for Disease Control are trying to do."⁶

Revealing more of the reasoning behind opposition to sexual behavior research, Dornan added, "Surveys based on personal and intimate subjects should not end up being the basis for public policy," and "...the results of the survey on sexual behavior end up becoming the basis to teach school children about homosexual sex; surveys revealing not enough knowledge about sex encourage the sexperts to develop new programs, and surveys revealing that children know a lot about sex encourage the sexperts to develop more programs to handle the flow of information and traditional families lose either way."⁷ While advocates for research were pleased that the Dornan amendment failed, 131-291, they were disheartened to see that close to one-third of the House agreed that sexual behavior research should receive no federal funding.

Dornan's statements and the vote on his amendment illustrate the need for advocates for behavioral and social research and advocates for comprehensive sexuality education to strengthen their partnership. The partnership will be critical if this legislation, like the other pieces of the Contract with America, is considered in the Senate, which has, on the whole, been less friendly than the House on the issue of sexual behavior research.

Free Speech and Telecommunications. Advocates of comprehensive sexuality education should also form alliances with advocates for free speech and telecommunications. In February, Sen. James Exon (D.-NE) and Sen. Slade Gorton (R.-WA) introduced the Communications Decency Act, which would impose jail terms of up to two years and fines of up to \$100,000 on individuals or companies that originate or solicit material for on-line networks that is deemed "obscene, lewd, lascivious, filthy or indecent." The intention of the bill's sponsors is to make the originators or solicitors of the material, not the on-line networks, liable. When Senator Exon introduced the measure, he indicated it was meant to protect minors from the pornographic material that is found on many on-line ser-

"...legislation dealing head-on with sexuality issues was largely ignored by the media and may even have escaped the attention of advocates of these issues."

vices. He later stated, "I want to keep the information superhighway from resembling a red-light district."⁸

While Senator Exon has indicated that the legislation is not intended to apply to private communication between consenting adults, it is unclear how bulletin boards and on-line education services that provide information and discuss sexuality issues will be viewed under the legislation.

This bill, which was included in a telecommunications reform legislation that passed the Senate Commerce Committee on March 23, angered many civil libertarians who believe that it impinges on constitutionally protected free speech. At the heart of the matter is the categorization of computer on-line services: Are they more akin to television and radio, or to print media? If the former, the legislation would be consistent with the federal government's established rules prohibiting the broadcast of obscene materials. However, if on-line services are more like the print media, some critics of the Exon-Gorton bill argue, the legislation holds on-line services to a stricter standard than applies to the print media—as photographs or text that may be permissible in a magazine would be barred from the on-line version of the publication. Critics also point out that many on-line services offer parents control features that could be used to prevent their children from accessing inappropriate material. Although most opponents are concerned about the harmful principles the legislation puts forth, others criticize its impracticality: in reality, the kind of policing the legislation prescribes would be virtually impossible because of the high speed by which information is transferred via telecommunications technology.

The Clinton administration initially took a position against the bill. A spokesperson stated: "The Administration abhors obscenity, in whatever form it is transmitted, but there are important First Amendment issues that need to be addressed before legislation is rushed through. We ought to have a serious approach—such as hearings—to find the best solution."⁹ The president later commented that he is undecided about the bill because he has not studied it. He indicated that he is sympathetic to the idea of the bill, saying parents should not have to "sit idly by" while their children download sexually explicit materials "more raw and more inappropriate than those things we protect them [from] when they walk in a 7-Eleven."¹⁰

Sexual Orientation. Rep. William Goodling (R.-PA), chair of the House Economic and Educational Opportunities Committee, has indicated that he has no intention of holding hearings this session on the subject of how classroom sexuality education addresses sexual orientation. Representative Goodling indicated that he had no knowledge of Speaker Newt Gingrich's promise to hold hearings on the subject in the spring or summer of 1995 and stated

that the committee has a "full agenda."¹¹

However, in the same week that Representative Goodling revealed that the speaker's hearings were not going to take place, Gingrich was again making comments to the media on gay and lesbian issues because of a district court ruling on the administration's policy regarding gay men and lesbians in the military. Federal Circuit Court Judge Eugene Nickerson's decision in the case *Able et al. v. U.S.* found the so-called Don't Ask, Don't Tell military policy unconstitutional because it violated gay and lesbian service members' First Amendment right to free speech and Fifth Amendment guarantees to equal protection. Opponents of the policy are optimistic that if the Justice Department challenges the ruling, the Second Circuit Court of Appeals will uphold Judge Nickerson's decision.¹²

Speaker Gingrich has indicated that the Congress will "probably go back to the rules" that existed before the current policy, and said that House Republicans would try to restore an outright ban on military service by gay men and lesbians by attaching an amendment to the Department of Defense appropriations bill.¹³ However, two days later, Gingrich indicated that the House will not revisit the issue if the Second Circuit Court of Appeals strikes down Judge Nickerson's decision.¹⁴

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TALK SHOW CHAOS

Debra W. Haffner, M.P.H.

I was not particularly surprised when I read about the murder of Scott Amedure. Amedure was the guest on the *Jenny Jones* show taped in early March but never aired who told a neighbor that he had a crush on him. The studio audience presumably reacted with shock. Jonathan Schmitz, the neighbor, reportedly said on the program that he was flattered but was heterosexual. Three days later, after receiving a note from Amedure, Schmitz allegedly went to his home and killed him with a shotgun. Schmitz surrendered to the police, saying that he could not live with the embarrassment the show had caused him. The story received substantial attention in the press, but regrettably, the homophobia surrounding the murder was barely mentioned. What is it about our culture that made this man feel so threatened by homosexuality that he would murder another man who publicly expressed sexual interest?

The murder has focused attention on the excesses of the talk shows. Even *TV Guide* ran a cover story entitled "Are Talk Shows Out of Control?"

The daytime talk shows have surpassed the soap operas in the amount of sexuality information (and misinformation) they bring into American homes on a daily basis, and they seem to become ever more sensational and exploitive. In the past year, I have witnessed several "surprises" related to sexuality issues, designed to embarrass the guests and titillate the audience. I have wondered about the emotional damage these shows might do to the people who volunteer the most intimate parts of their lives in front of a studio audience.

More than twenty talk shows air daily, and the number seemingly grows by the month; two cable stations now offer talk shows all day. These programs have become so familiar to us that their hosts are known by their first names. Who has not heard of Phil, Oprah, Geraldo, Sally, Rolonda, Ricki, and Jenny?

Sexuality issues are a major fare of these programs. During just one week in April, talk shows covered such topics as "sex maniacs," teenage prostitutes, women abused by their daughters, matchmaking, jilted lovers, man-stealing friends, marriage versus cohabitation, mismatched couples, and bigamy.

On April 12, one could have watched "Nice Guys versus Bad Boys" on *Leeza*, "Sex Ruins Friendships" on *Jerry Springer*, "Men Jealous of Lovers' Friends" on *Maury Povich*,

"Cheating Newlyweds" on *Sally Jessy*, "Domestic Violence" on *Rolonda*, and "Doctors with AIDS" on *Oprah*.

Talk show treatment of these issues is often lurid and exploitive. For example, a recent *Jerry Springer Show* called "I'm Proud to Be a Virgin" had a young teenager interviewing young women, who were hidden behind a screen, about becoming his first lover. The questions and answers increased steadily in lasciviousness. For an additional humiliating twist, the young man's best friend had accompanied him on the show, unaware that one of the young women behind the screen was his eighteen-year-old virgin sister.

"Experts" are routinely brought in toward the end of these broadcasts, in order for these shows to appear "responsible." Sometimes, these experts are highly qualified professionals; other times, I have been appalled by the advice I have heard these people give.

During my years at SIECUS, I have appeared regularly on daytime talk shows. And sometimes I have felt exploited and misused by the producers. On the *Montel Williams Show*, after being told that I was coming on to talk about safer sex in the 1990s, I was asked to provide advice to two young adults who have thousands of partners each year but refuse to use condoms. On this same program, the host told people to avoid dentists so as to prevent becoming infected with HIV! For a *Rolonda* show, I was told I would be speaking with some young people who had had intercourse and some who were virgins. The virgin turned out to be a beauty pageant winner from Texas whose performance for the talent contest of the beauty pageant had consisted of delivering a speech on virginity; the sexually active teenagers were six young men from Chicago who belong to the We Like to Freak Club, an organization of boys who have had more than a hundred sexual partners. On that same show, a young woman revealed to her mother that she had thought she was pregnant and that the producers had taken her for a pregnancy test.

My latest adventure was on the late-night program *Last Call*. The subject was the teenage chastity movement. Before agreeing to appear, I had spoken with the producer about the other guests and the format of the show. She had said I would be participating in a serious discussion with a representative from the True Love Waits campaign. The other guest and I were in for quite a shock when Stuttering

John, Howard Stern's sidekick, came bounding onto the set—unannounced to us—to question us about our personal sexual experiences. The show concluded without us after the second segment, when we refused to respond to John's outrageous tirades. After I left the set, I angrily asked the producer why she had not told me about Stuttering John. She answered, "Because you wouldn't have come."

I have decided to stop appearing on television talk shows. SIECUS staff will appear only on news programs where we are assured that the coverage will be balanced and thorough.

I would like to ask you to consider to do the same. The presence of experts on entertainment talk shows legitimizes the sensationalism and exploitation. Inevitably, the experts are given less than five minutes to "clean up" the emotional damage or the chronic misinformation.

Now, I know some of you are thinking, "But if we don't go on, who will?" I used to think that, too, until I realized that in one or two segments, no matter how good educators are, we do not have the time or opportunity to get our message across; we are not given a chance to correct the vast amount of misinformation that has been put forth. Similarly, counselors and therapists do not have time to address the emotional issues that have been raised and exploited. Five or ten minutes on a talk show is not therapy, nor is it ample time to educate the viewing audience on the issues. What would happen to the shows' formats if all sexuality professionals refused to participate—at least unless certain conditions were met. At minimum, I hope you will assess whether the topic is important, whether the coverage will be balanced, and whether the guests will be adequately briefed on the content and their role on the show.

I would also like to ask you to consider developing a policy not to refer clients or students to appear as guests on these shows. The SIECUS Mary S. Calderone Library regularly receives calls from producers looking for guests to talk about their experiences with infidelity, fetishes, betrayal, celibate marriages (a frequent request last year), and other

such issues. Staff always respond that we cannot help them. I feel strongly that such shows have the potential to harm individuals, and that it is not appropriate or ethical to help the producers find guests to exploit.

On the other hand, I think it is incumbent upon us to try to educate the producers of these shows, who have a tremendous opportunity to educate the American public responsibly about sexual issues. They have the skills, resources, and talents to help create an improved climate for sexual health.

To that end, I suggest that the talk shows reevaluate their role in promoting sexual health and sexuality education in America. I hope that they will make a commitment to providing information on the many sexuality-related topics that Americans need and want to know about: safer sex; HIV prevention; talking with children about sexuality; maintaining romance and intimacy in long-term relationships; growing up gay, lesbian, or bisexual; sexual abuse; sexuality and aging; the sexuality needs of people with disabilities; and so on. They could also provide a forum for debate on the public policy issues surrounding sexuality, such as welfare reform, health care reform, gay men and lesbians in the military, HIV prevention, and sexuality education. The shows could make a commitment to include information about and hotline numbers for places that can provide additional information. They could highlight stories about adolescents who are making contributions to their communities or the larger society. Producers and hosts could make a commitment to educating themselves about the sexual health needs and problems of their viewers. Guests could be helped to develop the skills needed to engage in consensual, nonexploitive, honest, pleasurable, and responsible relationships.

One of our most important roles as sexuality professionals is to assure that people have the information and skills to make responsible sexual choices. The media are uniquely situated to assist us in that goal. Let us hope we can help them to do it better.

NEW VIDEO FROM SIECUS

Sexuality Education for the 21st Century, a sixteen-minute video designed to assist school boards, community advisory boards, teachers, and parents in making decisions about the type of sexuality education to offer in schools, is now available. The video makes the case for comprehensive sexuality education by presenting interviews with students, teachers, doctors, researchers, and religious leaders, and by describing the content of accurate, effective programs.

To order, please send \$9.95 plus \$3.00 for postage and handling to SIECUS Publications, 130 West 42nd Street, Suite 350, New York, NY 10036.

**Body, Sex, and Pleasure:
Reconstructing Christian
Sexual Ethics**

Christine E. Gudorf

Cleveland, OH: The Pilgrim Press, 1994,
288 pp., \$19.95

The development of a sexual theology is the contemporary search for the Holy Grail. In *Body, Sex, and Pleasure*, Christine E. Gudorf joins the quest. Readers are challenged to be pilgrims.

The key to this book is in the subtitle: Gudorf makes a strong case for restructuring Christian sexual ethics. She locates the problem with churches "paralyzed by fear of stepping away from...the Christian sexual tradition" and advocates for a new, experiential-based theology and ethics.

Gudorf reviews the last two decades' discussion about a sexual theology and presents an articulate overview of the current agenda of Christian ethics in the United States. She touches the issues of the authority of the Bible and tradition, struggles valiantly with natural law, and brushes against science and technology. Solidly grounded in Western Christian theology, however, her discussion pays little attention to other traditions. Whether because of diplomacy or temerity, she never identifies the foes or champions of a sexual theology. Sadly, she offers no examples of sexual ethics derived from reflective experience.

For over a decade, nearly all the Western faith communities have addressed sexuality. Some have confronted particular issues—external ones, such as homosexuality, sexuality education in public schools, AIDS, and abortion; or internal ones, such as the ordination of women and gay and lesbian people. All have dealt with sexual harassment and abuse. Some have attempted to develop a sexual theology; these efforts have met with serious internal opposition and, often, defeat.

Thus, although Gudorf implies otherwise, it is not true that American faith communities and religious leaders have not made serious efforts at developing the sexual theology that she envisions. Labeling these leaders and their efforts the problem does not serve the search for a new sexual theology. Whatever the outcome, those who have crafted documents and policies for denominational governing bodies deserve loud praise: it is long overdue. One of the most progressive documents, "Sexuality: The Divine Gift," was produced by the Episcopal church in 1986. A nervous church bureaucracy withdrew it after an uproar caused by a misguided newspaper columnist (a fate shared by a Presbyterian document). As often happens, more people read, and believed, the columnist than the document itself, which presented the very theological position Gudorf espouses—that the body, sex, and pleasure are gifts from God. Perhaps Gudorf's work will enable

the message to now be heard more clearly.

Acknowledging that ethicists have contributed to the beginnings of a sexual theology, Gudorf contends that "most of this work is not readily intelligible to the general Christian public." I beg to differ. I have used the work of James Nelson (one of the ethicists Gudorf mentions) with several study groups, and it is not only intelligible but generative. Furthermore, through the work of such scholars as Elizabeth Schussler Fiorenza, Carter Heyward, and Beverly Harrison, the new theology is making its way into higher education faculties of theology, religion, philosophy, medicine, biology, psychology, and sociology.

What is needed is less polemic and more analysis of what has happened and why progress has been so slow, fewer homilies and more support for those who are leading religious communities toward a new sexual theology.

A reflective approach spawned liberation theology and feminist theology. Gudorf is correct in calling for a similar approach to sexual theology and ethics. In this book, she advances toward her goal. The journey will probably be long, but the book offers hope that Gudorf will keep the end in sight, nurture the pilgrims on the way, and help mark the path.

Reviewed by Charles A. Cesaretti, Episcopal priest, member of the board of the Center for Sexuality and Religion.

**AMERICAN SCHOOL HEALTH ASSOCIATION
PASSES RESOLUTION ON SEXUALITY EDUCATION**

In October 1994, the board of directors of the American School Health Association (ASHA) approved a resolution on sexuality education. ASHA summarizes the resolution as follows:

The American School Health Association recognizes that sexuality is a natural and healthy part of living, and that sexuality education is a complex and sensitive area of study. Because the majority of parents desire that their children receive sexuality education in school, ASHA recommends that sexuality education exist within a comprehensive school health program in order to demonstrate the interrelationship of health behaviors. The Association also recommends that teachers be well-trained, that the school provide an arena for cultural interactions and that curricula avoid stereotypical references. ASHA supports sexuality education that addresses human development, relationships, personal skills, sexual behavior, sexual health and sexuality within society and culture in the cognitive, the affective and the behavioral domains.

A SIECUS Annotated Bibliography of Available Print Materials

T

he last decade has seen a growing awareness of the prevalence and the implications of child sexual abuse in our society. Research has been conducted, stories on child sexual abuse have appeared in the mass media, and prevention curricula have been developed in response to the growing concerns of parents, educators, and other caring adults. This bibliography focuses on materials aimed at children, adolescents, parents, and professionals that provide information on the prevention, education, and treatment of child sexual abuse. Information on other topics, such as detection, reporting, and litigation, can be obtained from the organizations listed at the end of the bibliography or from the Mary S. Calderone Library at SIECUS, which is open by appointment to SIECUS members and accessible to the general public by phone. All of the resources in this bibliography can be ordered from the publishers or distributors, and some are available at public libraries.

Copies of this bibliography can be ordered from the SIECUS Publications Department at the following prices: 1-4 copies, \$2.00 each; 5-49 copies, \$1.75 each; 50-99 copies, \$1.50 each; 100 or more copies, \$1.25 each. SIECUS is located at 130 West 42nd Street, Suite 350, New York, NY 10036; 212-819-9770.

This bibliography was prepared by Evan Harris, librarian, SIECUS.

RESOURCES FOR CHILDREN

Better Safe Than Sorry

Judith Gordon and Sol Gordon

Meant for children aged 3-10, this book offers sexual abuse prevention messages and encourages children to communicate with parents and other caregivers. The book stresses the importance of seeking help and asking questions, assuring children that adults will support and protect them. 1984, 39 pp., \$8.95.

Prometheus Books, 59 John Drive, Buffalo, NY, 14228, 800-421-0351.

It Happens to Boys Too

Jane A. W. Satullo and Roberta Russell

This resource, geared for boys aged 5-12, focuses on the factors that make discussion and prevention of child sexual abuse difficult for boys. It provides the tools boys need to talk about sexual abuse, and includes messages for parents and teachers. Designed so that boys can read together with parents or teachers or on their own, the book is a good resource both inside and outside the classroom. 1992, 35 pp., \$8.95. *Rape Crisis Center of the Berkshires Press, 18 Charles Street, Pittsfield, MA 01201, 413-442-6708.*

Margaret's Story—Sexual Abuse and Going to Court

Deborah Anderson and Martha Finne

A child tells the story of going to court, including meeting with lawyers and testifying. The story helps to demystify the court system and addresses the anxieties of children involved in court cases or litigation related to sexual abuse. 1986, 45 pp., \$9.95.

Macmillan Children's Group, 866 Third Avenue, New York, NY 10022, 800-257-5755.

The O.K. Bears Coloring Book

Planned Parenthood of East Central Illinois

Sexual abuse prevention skills are presented through a rhyming story about good and bad touches. Interactive and engaging, this oversize coloring book is designed for children aged 3-8. 1984, 16 pp., \$1 plus 15 percent postage and handling.

Planned Parenthood of East Central Illinois, 318 West Washington Street, Third Floor, Bloomington, IL 61701, 309-827-4368.

My Body Is Private

Linda Walvoord Girad

Written from the point of view of a child, this storybook takes up privacy, family relations, and self-confidence as its main

issues. Both the mother and the father in the book are active participants in the child's preventive education, and encourage her to be assertive. The book uses correct anatomical terms in dialogue, and is written for children aged 5-12. 1984, 32 pp., \$4.95. *Albert Whitman and Company, 5747 West Howard Street, Niles, IL 60648, 800-255-7675.*

My Personal Safety Coloring Book

Barbara Zandio Hutchinson and Elizabeth Anne Chevalier

This oversize coloring book is an interactive, helpful tool for preventive education around sexual and physical abuse. It gives children the opportunity to draw pictures for the text and actively participate in their own learning experience. The book is appropriate for children under six. 1982, 23 pp., \$1.25. *Friedly Police Department, 6431 University Avenue, NE, Friedly, MN 55432, 612-571-3457.*

Something Happened and I'm Scared to Tell

Patricia Kehoe

This storybook, written for children aged 3-7, discusses the confused feelings of a little girl who has been sexually abused.

CHILD SEXUAL ABUSE: PREVENTION, EDUCATION, AND TREATMENT

The lion narrator encourages children who have been sexually abused to go on with strength and courage. 1987, 26 pp., \$4.95. *Parenting Press, PO Box 75267, Seattle, WA 98125, 800-992-6657.*

A Very Touching Book

Jan Hindman

This book teaches correct terms for body parts and discusses the different types of touches and other physical contact. Through humor and active participation exercises, it encourages open communication between adults and children. 1983, 44 pp., \$11.95.

The Hindman Foundation, 49 Northwest First Street, Suite 6, Ontario, OR, 505-889-8938.

What Every Kid Should Know about Sexual Abuse

Channing L. Bete Company

This coloring book for children aged 7-12 offers activities to teach about sexual abuse and how to prevent it. *Available in Spanish.* 1989, 16 pp., \$1.50.

Channing L. Bete Company, 200 State Road, South Deerfield, MA, 48413, 413-665-7611.

Touching

Whatcom County Opportunity Council
Coalition for Child Advocacy
Jody Bergsma, *illustrator*

The purpose of this storybook, intended for parents to read to young children, is to prevent sexual abuse by opening lines of communication between parents and children. The beautifully illustrated book emphasizes parental support, understanding, and protection of children. 1985, 16 pp., \$5.95.

Brigid Collins House, 1210 Indian, Bellingham, WA 98225, 206-734-4616.

Sarah

Illana Katz

This picture book, for children aged 5-10, tells the story of Sarah, a little girl who is sexually abused by her uncle. The

book is sensitive, well written, and successful in sending children the message that they have a right to privacy and protection. 1994, 44 pp., \$16.95.

Real Life Story Books, 19430 Business Center Drive, Northridge, CA 91324, 818-993-6955.

When I Was Little Like You

Jane Porett

In this large-format picture book, the author shares her experience as an adult survivor of childhood sexual abuse. The book is designed to support children and send the message that some secrets should not be kept. 1993, 30 pp., \$12.95.

Child Welfare League of America, 440 First Street, NW, Suite 310, Washington, DC 20001-2085, 202-638-2952.

RESOURCES FOR ADOLESCENTS

Abby, My Love

Hadley Irwin

Recommended for young people aged twelve and up, this story of two adolescents, and how one helps the other cope with feelings about incest, emphasizes the importance of patience and understanding in helping others overcome sexual abuse. 1985, 146 pp., \$11.95.

Atheneum Publishing, 866 Third Avenue, New York, NY 10022, 212-702-2000.

For Guys My Age: A Book about Sex Abuse for Young Men

Matthew Taylor and
Ann Heiss Schulte, *editors*

Written by a young man who has been sexually abused, this clear, direct booklet addresses the concerns of young men who have suffered abuse, including issues of strength and weakness, masculinity, and relationships. 1990, 19 pp., single copies free. *Hawthorne Center, 18471 Hagerty Road, Northville, MI 48167, 810-349-3000.*

A Survivor's Guide

Sharice A. Lee

This book explains the impact of sexual abuse and emphasizes the importance of seeking counseling. The book also discusses coping with feelings related to the abuse and communicating them to others. 1995, 102 pp., \$13.95.

Sage Publications, PO Box 5084, Thousand Oaks, CA 91359, 805-499-9774.

Coping with Incest

Deborah Miller and Pat Kelly

This book discusses the incest taboo, addresses myths and misconceptions surrounding incest, and provides a comprehensive discussion of the topic. Case studies help the reader understand the complexity of the issue and the different forms sexual abuse takes. 1992, 162 pp., \$15.95.

Rosen Publishing Group, 29 East 21st Street, New York, NY, 10010, 800-237-9932.

Shining Through: Pulling It Together after Sexual Abuse

Mindy B. Loiselle and Leslie Bailey Wright

This thoughtfully written workbook includes exercises and activities for adolescents who have been sexually abused. With an emphasis on feelings and how to cope with them both inside and outside therapy, the book is meant to be a learning tool. 1995, 94 pp., \$12.00.

The Safer Society Press, PO Box 340, Brandon, VT 04733, 802-247-3132.

Telling

Marilyn Reynolds

This novel tells of Cassie, a twelve-year-old girl who is molested by the father of the children she baby-sits. The secret comes out, and causes trauma of everyone involved—Cassie, her parents, the molester, and his family. 1995, 186 pp., \$7.95.

Morning Glory Press, 6595, San Haraldo Way, Buena Park, CA 90620-3748, 714-828-1998.

Everything You Need to Know about Incest

Karen Bornmann Spies

Defining incest and identifying the forms it takes, this book is a helpful source of information for teenagers. The book includes a bibliography, glossary, and information on where teenagers can seek help if they have been sexually abused. 1992, 64 pp., \$15.95.

The Rosen Publishing Group, 29 East 21st Street, New York, NY 10010, 800-237-9932.

Everything You Need to Know about Sexual Abuse

Evan Stark

This informative and thorough discussion of sexual abuse includes sections on what sexual abuse is, who is affected by abuse, and how to prevent it. 1993, 64 pp., \$15.95.

The Rosen Publishing Group, 29 East 21st Street, New York, NY 10010, 800-237-9932.

In Their Own Words: A Sexual Abuse Workbook for Teenage Girls

Lulie Munson and Karen Riskin

This workbook includes the words and experiences of young women who have been sexually abused, as well as valuable information on sexual abuse and related topics. The text describes how sexual abuse affects adolescents, and includes questions directed at the reader that are designed to help her clarify her feelings. 1995, 96 pp., \$10.95.

Child Welfare League of America, 440 First Street, NW, Suite 310, Washington, DC 20001-2085, 202-638-2952.

Uncle Vampire

Cynthia Grant

This novel tells the story of sixteen-year-old twins, Carolyn and Honey, and how each deals with being sexually abused by their uncle, who lives with the family.

While Honey wants to ignore the incest and preserve the appearance of normalcy, Carolyn reveals "Uncle Vampire's" true nature. 1993, 160 pp., \$13.95.

Atheneum, 866 Third Avenue, New York, NY 10022, 212-702-2000.

The Storm's Crossing

Reanne S. Singer

The main character of this novel is a seemingly typical "girl next door," who, despite the appearance of normalcy, struggles with incest and the storm of feelings inside her. The book is a message to young people that it is their right to draw boundaries and refuse uncomfortable touch, and they are not alone. 1993, 163 pp., \$13.95.

Deaconess Press, 2450 Riverside Avenue South, Minneapolis, MN 55454, 800-544-8207.

RESOURCES FOR PARENTS

The Mother's Book—How to Survive the Incest of Your Child

Carolyn M. Byerly

This book discusses the cultural attitudes that define mothers as the primary caregivers of children and addresses the issues of guilt that arises after the discovery of incest. This thorough and sensitive resource addresses child protection and the process of rebuilding familial relationships after incest, and includes a helpful section for lesbian mothers. 1992, 59 pp., \$6.95.

Kendall/Hunt, 4050 Westmark Drive, Dubuque, IA 52004, 319-589-1000.

Spiders and Flies— Help for Parents of Sexually Abused Children

Donald Hillman and Janice Solek-Teft

This book provides information on the evolution of views on child sexual abuse, and covers a broad range of concerns within the topic, including typical scenarios of abusive encounters and the long- and short-term effects of sexual abuse. It also

presents a review of normal childhood sexual development. 1988, 200 pp., \$12.95.

Simon and Schuster, 200 Old Tappan Road, Old Tappan, NJ 07675, 800-223-2336.

When Your Child Has Been Molested

Katheryn B. Hagens and Joyce Case

This book identifies the feelings, concerns, and difficulties parents encounter after discovering the sexual abuse of a child. The authors discuss legal proceedings and include a "Reality Check" section at the end of each chapter to help readers define their feelings. 1988, 159 pp., \$10.95.

Simon and Schuster, 200 Old Tappan Road, Old Tappan, NY 07675, 800-223-2336.

Especially for Parents

DeAnn Yamamoto-Nading

This booklet addresses questions and issues commonly raised by the parents of children who have been sexually abused. It focuses on helping parents cope with their own feelings, as well as support the child. 1991, 23 pp., \$2.50.

King County Sexual Assault Resource Center, PO Box 300, Renton, WA 98057, 206-226-5062.

He Told Me Not to Tell

Jennifer Fay

Focusing on communication, this booklet serves as a parents guide for talking with children about sexual abuse. It offers concrete advice on how to help prevent sexual abuse through parental support and education. 1991, 28 pp., \$2.50.

King County Sexual Assault Resource Center, PO Box 300, Renton, WA 98057, 206-226-5062.

A Frog Talks More about Touching

Nancy O'Mara

Designed for children in grades K-6 and their parents, this resource is a script for

CHILD SEXUAL ABUSE: PREVENTION, EDUCATION, AND TREATMENT

a series of skits. The booklet provides parents with basic information on sexual abuse and teaches children the safety rules of touching. The interactive nature of the skits communicates to children that support is available from parents and other caring adults. 1993, 31 pp., \$19.50.

King County Sexual Assault Resource Center, PO Box 300, Renton, WA 98507, 206-226-5062.

CURRICULA **(Preschool and Grade School)**

Talking about Touching

Ruth Harms

The *Talking about Touching* program is composed of three curricula: preschool-kindergarten, grades 1-3, and grades 4-5. Each curriculum focuses on teaching children skills in assertiveness, decision making, and use of family and community resources. Each includes teacher guides and eleven-by-seventeen-inch lesson cards. 1990, preschool-kindergarten kit (27 lessons), \$235.00; grades 1-3 (46 lessons), \$155.00; grades 4-5 (41 lessons), \$140.00. *Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134, 800-634-4449.*

"No-Go-Tell!": Information for Teachers and Parents

Elisabeth J. Krents and Dale V. Atkins

Intended to be used alone or integrated into an existing safety program, this program is designed for preschool and early elementary school children. The curriculum includes male and female anatomically correct dolls, poster cards, a parents and teachers guide, and a postinstruction assessment test. The curriculum focuses on teaching young children assertiveness skills and encouraging them to communicate with caring adults. 1991, 69 pp., 89 poster cards, \$299.00.

James Stanfield Company, PO Box 41058, Santa Barbara, CA 93140, 805-897-1185.

Soapbox Productions: The Touching Problem

Sandra L. Kleven and Joan Krebill

This curriculum for children in elementary grades is a compilation of the scripts used by the Soapbox Players, an educational theater group. The scripts send a prevention message, giving children information on different types of touches and what sexual abuse is. The curriculum also includes information for educators on how to start an educational theater company or use theater as a tool for prevention education. 1986, 63 pp., \$25.00.

Brigid Collins House, 1210 Indian, Bellingham, WA 98225, 206-734-4616.

Personal Safety: Curriculum for Prevention of Child Sexual Abuse

Mary Olsen et al.

This curriculum is designed to send prevention messages, and to teach personal safety, assertiveness, and how to find support systems. Separate curricula are available for preschool; grades K-2, 3-4, and 5-6; junior high; and high school. The lesson plans and concepts contained in each are appropriate to the age and developmental stage of the students, and each curriculum includes information for the teacher and an overview of the curriculum and its aims. 1982, 165 pp., \$20.00 for each curriculum.

Child Abuse Prevention Program, Tacoma School District, PO Box 1357, Tacoma, WA, 206-572-5541.

Red Flag Green Flag People

Jay Williams

Red Flag Green Flag People's Facilitator Guide

Carol Grimm and Becky Montgomery

This coloring book teaches children in early elementary grades to identify green flag (appropriate) and red flag (inappropriate) touch. It provides examples of situations in which both kinds of touch occur

and fill-in-the-blank exercises. The facilitator program guide reprints each page of the children's book with an explanation of its educational aim and suggests classroom activities. 1992; coloring book, 30 pp., \$3.00; facilitator guide, 38 pp., \$11.95.

Rape and Abuse Crisis Center, PO Box 2984, Fargo, ND 58101, 800-627-3675.

Red Flag Green Flag ABC's of Personal Safety

Carol Grimm

This alphabet book for preschoolers links each letter to a personal safety message, stressing "always be careful" as a theme. Suggestions for role-plays and facilitator notes are included. 1994, 30 pp., \$3.00.

Rape and Abuse Crisis Center, PO Box 2984, Fargo, ND 58101, 800-627-3675.

CURRICULA **(Junior and Senior High School)**

About Sexual Abuse: A Program for Teens and Young Adults

Fred and Betty Ward

This curriculum, developed for the Unitarian Universalist Association, is designed to help participants become aware of sexual abuse, understand abusive behavior, and explore their feeling about sexual abuse. Each module of the program includes a description of the goals to be met, materials needed, background information, and activities. 1990, 85 pp., \$5.00. *Unitarian Universalist Association Bookstore, 25 Beacon Street, Boston, MA 02108, 617-742-2100.*

No Easy Answers: A Sexual Abuse Prevention Curriculum for Junior and Senior High Students

Cordelia Anderson

The twenty lessons in this curriculum are designed to help students develop communication and prevention skills, understand the many types of touch, and explore their

CHILD SEXUAL ABUSE: PREVENTION, EDUCATION, AND TREATMENT

feelings and thoughts related to sexual abuse and exploitation. 1982, 208 pp., \$29.95.
Illusion Theater, Prevention Department, 528 Hennepin Avenue, Suite 704, Minneapolis, MN, 612-339-4944.

Personal Safety and Decision Making

Ann Downer and Kathy Beland

Assertiveness and decision-making skills are taught in this curriculum for grades 6-8. Group discussion, role-play, and the analysis of story scenarios help young people understand the dimensions of sexual abuse. A teachers guide is included. 1988, 116 pp., \$110.00.

Committee for Children, 172 20th Avenue, Seattle, WA 98122, 206-322-5050.

RESOURCES FOR ADULTS

Adults Molested as Children: A Survivor's Manual for Women and Men

Euan Bear and Peter Dimock

This booklet emphasizes recovery and seeking support, and discusses how to choose a therapist. 1988, 67 pp., \$12.95.

The Safer Society Press, PO Box 340, Brandon, VT 05733, 802-247-3132.

The Courage to Heal Workbook

Laura Davis

This binder-style workbook is a self-help tool for men and women coping with the aftereffects of childhood sexual abuse. It contains checklists, open-ended questions, writing exercises, art projects, and activities. 1990, 460 pp., \$18.95.

Harper & Row, 10 East 53rd Street, New York, NY 10022, 212-207-7000.

Victims No Longer

Mike Lew

Written by an expert on male victims of child sexual abuse, this resource helps

survivors identify and validate feelings and experiences. The text includes personal accounts of experiences related to sexual abuse, its aftereffects, and recovery. 1990, 325 pp., \$14.95.

Harper & Row, 10 East 53rd Street, New York, NY 10022, 212-207-7000.

The Male Survivor

Matthew Parynic Mendel

This book addresses the impact of sexual abuse on men, and discusses particular concerns and related issues. It stresses the need for parents, teachers, and society in general to acknowledge the phenomenon, and works to dispel myths attached to sexual abuse of boys. 1994, 238 pp., \$18.95.
Sage Publications, 2111 West Hillcrest Drive, Newbury Park, CA 91320, 805-499-0721.

Women's Sexuality after Childhood Incest

Elaine Westerlund

A report on the findings of a study on women with incest histories, this book includes case examples and a thorough discussion of them. Accessible and informative, the book is a good resource for anyone concerned with issues related to sexuality in women who were sexually abused as children. 1992, 241 pp., \$27.95.

W.W. Norton and Company, 500 Fifth Avenue, New York, NY 10110, 800-223-2584.

RESOURCES FOR PROFESSIONALS

Helping Abused Children: A Book for Those Who Work with Sexually Abused Children

Patricia Kehoe

This booklet is a tool for the counselor, teacher, or caregiver working with a child who has been sexually abused. It includes information and activities appropriate for children aged 3-12. 1990, 43 pp., \$8.95.

Parenting Press, PO Box 75267, Seattle, WA 98125, 800-992-6657.

A Guide to References and Resources in Child Abuse and Neglect

American Academy of Pediatrics

A comprehensive source of information for those interested in medical diagnosis and treatment of child abuse, this manual includes information for physicians and bibliographies on each of the many topics. Although this resource is not exclusively concerned with sexual abuse, it contains valuable information, and a section on sexual abuse by females. 1994, 198 pp., \$24.95.
American Academy of Pediatrics, Publications Department, PO Box 927, Elk Grove Village, IL 60009, 800-433-9016.

A Sourcebook on Child Sexual Abuse

David Finkelhor and Associates

This review of the research on sexual abuse includes chapters on the prevalence of abuse, abusers, initial and long-term effects of abuse, how to design studies, and prevention. 1986, 276 pp., \$22.50.

Sage Publications, 211 West Hillcrest Drive, Newbury Park, CA 91320, 805-499-0721.

Child Sexual Abuse: Intervention and Treatment Issues

Kathleen Coulborn Faller

This manual for professionals discusses the indicators, investigation, and treatment of child sexual abuse. The appendices includes a child sexual behavior inventory and guidelines for identifying signs of possible abuse. 1993, 116 pp., single copies free.
National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, DC 20013-1182, 800-394-3366.

The Future of Children (Volume 4, Number 2): Sexual Abuse of Children

Richard E. Behrman, editor

This volume of *The Future of Children*, a quarterly publication, is concerned with a

CHILD SEXUAL ABUSE: PREVENTION, EDUCATION, AND TREATMENT

wide range of topics relating to child sexual abuse, including treatment, prevention, and reporting.

*The David and Lucile Packard Foundation,
300 Second Street, Suite 102, Los Angeles, CA
94022, 415-948-3696.*

The National Resource Center on Child Sexual Abuse Bibliographies and Information Papers

The National Resource Center on Child Sexual Abuse makes available a wide variety of bibliographic resources on child sexual abuse. Sample topics include "On Sibling Incest," "Children as Witnesses," "On the Effects of Sexual Abuse on Children," and "On Non-offending Parents." Single copies free upon request.

The National Resource Center on Child Sexual Abuse, 2204 Whitesburg Drive, Suite 200, Huntsville, AL, 35801, 800-543-7006.

Breaking the Silences: Considering Culture in Child Sexual Abuse

Lisa Aronson Fontes, editor

This book examines the effect of culture on child sexual abuse, particularly its impact on intervention strategies. The book offers ways professionals can be more helpful to children, families, and adult survivors with diverse cultural backgrounds. Among the groups discussed are Cambodians, African-Americans, Seventh Day Adventists, gay men, and lesbians. 1995, 352 pp., \$24.95.

Sage Publications, 211 West Hillcrest Drive, Newbury Park, CA 91320, 805-499-0721.

A Review of Child Sexual Abuse Research: 1988-1991

*National Clearinghouse on Child Abuse
and Neglect Information*

This book is a compilation of the abstracts of selected studies and reports on sexual abuse culled from the Clearinghouse's database. 1994, 64 pp., \$7.00.

National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, DC 20013-1182, 800-394-3366.

National Clearinghouse on Child Abuse and Neglect Information

*PO Box 1182
Washington, DC 20013-1182
800-394-3366*

National Committee for Prevention of Child Abuse

*332 South Michigan Avenue, Suite 950
Chicago, IL 60604
312-663-3520*

The National Resource Center on Child Sexual Abuse

*107 Lincoln Street
Huntsville, AL 35801
800-543-7006*

The Safer Society

*PO Box 340
Brandon, VT, 05733
802-247-3132*

Survivors of Incest Anonymous

*World Service Office
PO Box 21817
Baltimore, MD 21222
410-282-3400*

JOURNALS

The Journal of Child Sexual Abuse

*The Haworth Press
10 Alice Street
Binghamton, NY 13904
607-722-5857*

Sexual Abuse: A Journal of Research and Treatment

*Plenum Publishing
233 Spring Street
New York, NY 10013
800-221-9369*

ORGANIZATIONS

The Hindman Foundation

*49 NW First, Suite 6
Ontario, OR 97914
503-889-8938*

VOICES in Action (Victims of Incest Can Emerge Survivors)

*PO Box 148309
Chicago, IL 60614
312-327-1500*