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The Pediatrician as Physician, Human Sexuality Educator, and Counselor of Young People and Parents

A Doctor Speaks Up

Murray M. Kappelman, MD

Professor of Pediatrics and Director of the Division of Behavioral and Developmental Pediatrics, University of Maryland School of Medicine

Because of the current rapid changes in social structure and sexual mores, pediatricians (and other physicians as well) are finding themselves in the unanticipated and unprepared-for role of human sexuality educator and counselor as well as physician to childhood and adolescent organic and emotional sexual problems. Many of today's pediatricians face these new roles with reluctance, trepidation, and concern. The reason for this is obvious: few now practicing in our country have had adequate educational training in human sexual behavior and intimate relationships in college or in medical school. Courses in human sexuality have been added only recently to some medical school curricula and the subject has begun to comprise a contemporary area of concern for those pediatricians with earlier training.

The public's expectation is that pediatricians are capable and trained in all current areas of childhood and adolescent care, including intimate human sexual behavior. Pediatricians know differently, however. They know that generally they are approaching the areas of childhood and adolescent sexuality from an extremely tenuous foundation, one primarily based only on their individual physician experiences and on what are really biases and personal value judgments.

Aware that the above personal guidelines are inadequate and inappropriate for the specific sexual problems of the young people that they treat, pediatricians may take refuge in one of many mechanisms to avoid involvement. They may signify, by behavior and words, that they are "too busy" and/or employ the often-abused cliche, "It is a phase which will be outgrown," as a catchall for the sexual problems of their patients and their families. They may also resort to quick and definitive judgments, based upon their personal ethical, moral, and religious tenets and upbringing, which may not be applicable to the situation at hand. Unfortunately, pediatricians are not the only physicians who have wished that the subject of sexuality within their private practice would conveniently disappear. However, given the nature of our times—and that childhood and adolescent sexuality are normal processes in the growth and development of *all* children—the practice of pediatricians, in particular, can clearly be expected to include such problems with ever-increasing frequency.

Why the Pediatrician?

During previous generations, it was usual for families to be extended, within a single environment, to grandparents, aunts, uncles, parents, and others. These people were

available for advice, counsel, setting of rules, and even discipline. Often their relationships to the children of the family were special in their caring and mutual trust. Today, the extended family has been disrupted and this break in the lines of communication, between the child and/or adolescent and members of the family other than the parents, has created a void in the ability to obtain a multiplicity of opinions and supportive interactions.

At one time in our past, religious institutions also played a significant role in the counseling and guidance of sexual matters among young children. However, although the sexual mores and ethical considerations of the young have dramatically changed over the past decade, some religious denominations have remained somewhat constant and inflexible in their tenets and responses to sexuality. This has created an almost irreparable alienation between the young person of faith and his or her particular religious institution in areas of intimate human behavior.

Moreover, often during the past years, other concerned adult role models took the time and effort to guide young people through the jungle of sexual confusion during the growing-up period. Guidance counselors, and health education and classroom teachers, often played this significant role. It is saddening to consider the fact that only a small number of health educators, and human sexuality educators and counselors, still perceive these issues to be part of their function in the educational and social lives of their students. Too frequently a "nine-to-five" attitude also limits these people in their roles as available sexuality educators for the young.

Thus, the vital areas of sexuality education and counseling of the developing young person are often placed directly in the hands of parents and siblings, peer groups, and family physicians. Many of our children and young adults, however, recognize a serious dichotomy between their philosophies about human behavior and those of their parents—particularly regarding the delicate subject of sexual behavior. Often emotional and intellectual barriers arise in families which are difficult to overcome. Most young people, in essence, know where their parents stand, know the degree of the strength and tenacity of their opinions and judgments, and refuse to "give in" to a philosophy on sexuality that derives from a previous generation. The peer group, by contrast, has been shown by research to have a significant impact on the sexual education of its members, especially in adolescence. But, today's quickly maturing young population often recognizes that their friends know little more about the subject than they do and, when serious sexual crises arise, reach out for a somewhat more professional and informed opinion. Whom, then, should they consult? It should be a person who has known them from birth and watched over their progress, if possible. And, it should be a person whose opinion they have learned to trust and respect, one who can provide a balanced perspective on relevant issues and problems. Because pediatricians and other physicians are often in this unique professional position, they must be prepared to play this role. However, to do so well, they must know the facts, the attitudes, the new social and sexual environment of the young, and the extent to which their own feelings, experiences, and judgments play a role in the advice, counsel, and education rendered to their patients within any pediatric age group.

When Does a Pediatrician's Role Begin?

The practice of preventive pediatrics is the essence of a successful pediatric practitioner's career. The better his or her preparation of the parent and child to prevent future physical and emotional problems, the healthier will be the child population. Thus, preventive pediatrics extends well beyond immunizations, nutritional advice, periodic

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Janet Jamar
Director of Publications
SIECUS
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checkups, and other routine aspects of child-care. Pediatricians must help parents to learn how to create emotional environments which will lead to future well-adjusted young adults. A significant facet of this preventive, behavioral, pediatric practice is in the area of human sexuality. Pediatricians can play an extremely important role in the sound sexual development, orientation, adjustment, maturation, and social health of their patients—from the time of infancy to late adolescence.

The Infant

During the infancy phase, pediatricians can and should play a significant role in the sexualization process of the child. The young infant, during its first year, will always begin to explore its body. Male and female infants will discover their genitalia, begin fondling these parts of the body just as they do their toes, fingers, and ears, and will experience a pleasurable reaction that they will wish to repeat. Parental response to this innocent and natural exploration can have a long-standing impact upon the young infant. Parents should be reassured that this is a natural phenomenon of self-discovery and that it should not be a cause for alarm. This should be done early enough so that parents will not scold or slap the child's hand to indicate that such self-exploration is "bad" and must not be continued. Pride and appreciation of one's body is one of the first bricks in the foundation of well-adjusted sexual behavior. The sense that one's body is "out of bounds," and that to touch oneself is evil and unacceptable, can create very early sexual inhibitions within a child. Parental discomfort and their unreal concerns must be dealt with by the pediatrician at this time. Reassurance, and a careful explanation of the vital and positive role such childhood self-discovery plays in adult sexual adjustment, is an important first step in assisting parents to a calm, rational, and healthy approach to their children's sexuality. To open this topic up with parents, when their infant is at or around the fourth month, a pediatrician might ask, "How does it make you feel when your child plays with his penis or her clitoris?" This will begin to alert parents to the concept that sexuality is a part of health.

The Growing Child

Children are naturally curious. They learn by asking, questioning, and exploring the world around them. During their young years, children turn to their parents for answers to those baffling questions that arise every day—many of which center around the area of intimate human behavior and sexuality. It is extremely important that the pediatrician advise parents to always respond openly and easily, in an age-related manner, to questions about sexuality. Often parents go into far greater detail about sexual matters than children can process at a particular intellectual and emotional age. This can frighten, confuse, and/or alienate the child. Or, on the other hand, they may attempt to use "the birds and the bees" approach to sexuality which, particularly with the child over five-years-of-age, will only result in the child's realization that the parents are refusing to deal honestly with sex in all its aspects. Subsequently, this will cause the youngster to be reluctant and, eventually, to refuse to approach his or her parents for advice on sexual matters. "Baby-talk" subterfuge insults the intelligence of even the youngest child and creates an atmosphere of storybook fantasy about human sexuality—a subject which should always be kept in the clear perspective of reality.

Pediatricians also must encourage parents not to wait too long for questions. Parents should make an early effort to introduce the subject of sexuality into their child's life in a gentle, subtle, yet meaningful, manner. Many outside sex-related events offer excellent oportunities to initiate appropriate conversations, such as watching a pet give birth to its young, watching a television program which deals with a sex-related subject, or overhearing slang words such as "queer" or "jerking off." Discussing such events will enable a child to approach adolescence in a well-informed, secure atmosphere and will help to create a natural transition from the sexual innocence of their childhood to a mature, informed sexual awareness in their early adolescence. Because a child's questions will change in complexity as the years advance, it is also important for pediatricians to prepare parents for the various questions that may arise.

Adolescence

Another aspect of the role that the pediatrician plays in the sexual development of patients is that of monitoring physical development. During the early adolescent period, overt body and internal physiological changes occur with great rapidity. Some young girls may feel a deep concern when they begin their menstrual cycle before or much later than their peer group; others may experience alarm when one breast appears larger than the other during their early development. The adolesecent boy may express concern about the size of his penis (is it too large or too small?); about the sudden and unexplained enlargement of one or of both of his breasts; and/or about the delay in sexual maturation he is experiencing in comparison to his peers. To adolescents, these differences may seem of catastrophic importance. Because pediatricians can be confident that these are normal phases of sexual development, it is vitally important for them to reassure early adolescent patients about these sexual bodily changes even when unasked. A youngster's failure to communicate his or her concern to a pediatrician can mask a high level of anxiety. The simple statement, "I notice that one of your breasts is growing at a faster rate than the other. This is quite normal," can allay a great deal of unexpressed anxiety. Telling a fourteen-year-old boy that you notice the beginnings of pubic hair, and that he should be catching up with his peers within a matter of a year or so, may immediately change the comfort level of his daily life and the way that he feels about himself.

As adolescence progresses, the pediatrician is confronted with problems of increasingly sophisticated sexual

complexity. Crisis issues, such as sexually transmitted diseases (STDs) and unexpected teenage pregnancy, are endemic within the adolescent population. There is no home that is immune, nor any physician's office without such cases, no matter what the socioeconomic level of the patient population. Aware of the current increase in early sexual activity, pediatricians must face the fact that young people need informed advice concerning contraception. In addition, charged emotional areas such as homosexuality, bisexuality, incest, and living together before marriage cannot be ignored as very real emotional issues within the practice of adolescent medicine.

Understanding Contemporary Adolescent Sexuality

If pediatricians are to function effectively as sexuality educators in the next decade, they must become informed about the changing patterns of sexuality that have taken place among teenagers during the last decade. Attempting to base one's advice and counsel on the sexual philosophies and mores of ten or twenty years ago, will result in being regarded as "old-fashioned" by the young population and thereby rejected as a trustworthy source of information and counsel. Times definitely have changed. This era's sexual revolution is over; and, in today's teenage society, sex is looked upon as a normal, natural, biologic, and healthy aspect of daily living.

The problem confronting adolescents is not whether sexual activity is acceptable behavior or not, but whether or not they wish to participate in the increasing degree of sexual activity that is occurring in their peer groups. Many considerations play a role in their decisions—religious, moral, family, and individual. Impacting on these decisions is peer group pressure. The sense of "belonging" is an integral aspect of adolescence. Teenagers, therefore, often enter the world of sexual activity and intercourse to become part of the crowd, not because they have an emotional, physical or intellectual desire to become involved.

It is essential that pediatricians, in their roles as sexuality educators and counselors, never assume the positions of judge, jury or lawmaker. The soundest and most rational basis of approach for pediatricians to take in their practice, regarding the sexual activities of young people, is to accept their sexual behavior as it exists at that moment. This does not mean encouraging or condoning activities which the pediatrician feels are inappropriate or overlooking significant problems which may result from sexual activity. But, it is important to know, understand, and accept where the teenager is coming from so that appropriate advice can be given when sought and needed. Refusal to deal directly with teenagers' concerns, whether they be early sexual activity, homosexuality, the need for contraception, or the desire to cohabit prior to marriage, will alienate teen patients. Moreover, negative interactions between pediatricians and their patients will only result in the former eliminating themselves from the scene as valued sexuality educators and counselors. What patients in the preadolescent and adolescent period need from pediatricians is not a rule book of moral behavior but advice, guidance, and education on how to cope with, and adjust to, the changing sexual mores of the teenage world in which they live. It is essential that pediatricians try to understand that world. Pediatricians advising and counseling today's teenagers using preformed judgments and biases will only add to the confusion, the frustration, and the pain of the young people who come to them as patients.

Pediatricians may have to face their difficulties in dealing with that world, however. There are areas of human sexuality that might prove too difficult for some to handle. Religious beliefs may hamper physicians in dealing realistically with contraception, abortion, and teenage pregnancy situations. One's moral and ethical upbringing may make it difficult to deal with new knowledge about homosexuality. Incest could be a "charged" area for some. For others, traditional concepts of family and marriage may be so well entrenched that attempting to deal with those who want to live together prior to marriage might prove impossible. Hopefully, most pediatricians will try to overcome their biases—whether religious, ethical or moral—in order to reach out and assist young people who have need for sound advice and counsel. However, if this cannot be done, the most important response to give is an honest one. The pediatrician should communicate to the young patient and/or parents that he/she cannot offer rational and reasonable advice that is based on today's moral and ethical standards; that he/she is not an "expert" on the subject; and that he/she is unable to deal with the problem but will be happy to make appropriate referrals to other physicians and/or to professionals in social agencies who do have the appropriate expertise. Such help can usually be found in the community.

Special Concerns of the Pediatrician as Physician, Sex Educator, and Counselor

Sexually Transmitted Diseases

At this time, the primary sexually transmitted diseases of concern are the bacterial infections, gonorrhea and chlamydia; the spirochetal infection, syphilis; and the retrovirus, HIV. Incidence of these have been rising rapidly across the nation, despite intensive public health measures to educate the populace and to eradicate their spread by careful follow-up on the sexual contacts of infected patients.

One frightening aspect of this increase is that teenagers are becoming the primary victims of the bacterial diseases. Cases have doubled among young people in the past two decades. Young adults, 20–24-years-old, rank first in the nation in incidence of gonorrhea, with 15–19-year-old teenagers in second place. The reported ratio of gonorrhea to syphilis among young people is about 20:1. Another alarming concern is the increase in penicillin-resistant

strains of gonococcus which are making treatment in some situations extremely difficult. In addition, adolescent attempts to use penicillin without physician guidance are resulting in under-treated and drug-resistant strains of gonococcus and partially treated syphilis with its primary stages masked and unheeded.

With changes in sexual techniques and partners a part of present adolescent experimentation, pediatricians must also be on the alert for signs of nongenital STDs: chancres around the lips, in the pharynx, or around the anus; and gonorrhea in the pharynx or the anal area. These have not been common places for pediatricians to look for STDs. They must now consider these areas, however, because both oral and anal sex are on the rise as part of teenage sexual experimentation, just as they have been in the adult population. Educating teenagers that the oral and anal areas should also be considered as potential sites for STDs is an added responsibility, and they must be cautioned that condoms should be used to protect all areas.

A second important consideration is educating teenagers to recognize sexually transmitted diseases when they occur. A young female should be alerted to the fact that such diseases may be indicated by only a subtle change in vaginal discharge, in contrast to the young male who may experience some dysuria (painful urination) and an unexpected but easily observable discharge from his penis. Physicians can impart this information in their offices; in schools; by using mass media; and by urging parents to convey this knowledge to their children.

The vast majority of cases of gonorrhea, chlamydia, and syphilis in teenagers are preventable and treatable. HIV infection is also preventable, although treatment for this disease eludes us at this time. Moreover, the laws of most states give minors the right to diagnosis and therapy for sexually transmitted disease without parental consent or even knowledge. This allows for the privacy that is helpful in convincing the infected teenager to seek medical help.

When one deals with teenagers it is important to realize that *they want facts*. They want to know *how* STDs are contracted; *how* they can escape infections if they are exposed; *how* they can recognize early signs and symptoms of infection; *how* these are normally treated; and *where* they can go for treatment. Giving adolescents this exact and useful information can significantly help to reduce the prevalence of STDs in the teen population. The pediatrician has direct responsibility to see to it that such health education is given every year to the community at large, and to his patients in particular, in one manner or another.

After helping a teenage patient through his or her first episode of a sexually transmitted disease, the physician should begin thorough, nonaccusative, and nonpunitive discussions about future use of measures of prevention. Judgment and moral fingerpointing can, in a few seconds, destroy the important rapport that has been built up between the pediatrician and adolescent over a painstaking period of time. Physicians must continue their efforts to make sure that teenagers are fully aware of their options and that they are provided with pertinent objective information. Remember, *ultimate decisions will be made only by the teenager* at the moment of his or her private sexual encounter, and a well-informed teenager will at least have the potential for acting more responsibly.

One reason for the alarming rise of STDs among teenagers is the shift in their methods of birth control. The condom, which was the favorite and virtually only safe STD-method of birth control for years, has been largely replaced by the pill, the intrauterine device, and the diaphragm—none of which, by themselves, prevent sexually transmitted diseases. Only the condom blocks semen from contact with female vaginal tissues and vice versa. A latex condom, with nonoxynol-9, also blocks the passage of the human immunodeficiency virus (HIV), and other viruses, in both heterosexual and homosexual intercourse and may save an adolescent's life. Wise advice to all adolescents then, male and female, is to consider seriously the use of a condom, especially when one has little knowledge of one's partner. Teenagers should have condoms ready and should use them with an attitude of preventive protection for both partners. They should be informed that the condom must be in place prior to insertion of the penis. Both partners should also be warned that unless such precautions are *consistently* used, they will be extremely vulnerable to a pregnancy and to the contraction of sexually transmitted diseases.

If a pediatrician discovers a sexually transmitted disease in a *preadolescent patient*, some form of sexual abuse must be considered. In this situation, it is important for the pediatrician, with the help of other agencies, to find the individual who has infected the young person; to take proper steps to prevent further abuse; and to initiate counseling help for the child.

Success in handling STDs will come from increasing the percentage of infection-free adolescents and also from teenagers and their parents being willing and able to confront prevention and treatment together.

Contraception

As with sexually transmitted disease legislation, almost all states currently have laws permitting teenagers to seek family planning and birth control advice without the knowledge or consent of their parents—even teenagers who are legally underage with respect to other activities. Also, physicians supplying medical contraception to adolescents are in no way obligated to report this to their parents.

Many mothers and fathers point with dismay at the drastic rise in adolescent sexual activity and place the blame for this directly on the availability of various methods of birth control. The facts are, however, that it is not availability of a

mechanism to prevent pregnancy that has increased the sexual activity of today's teenagers. Teenagers would have entered the sexual arena anyway, with or without appropriate contraception. The increased usage of contraception by this age group is the result of the expanded sexual liberation of the immediately older population of young adults. It is also the result of the acceleration of the adolescent's sexual-social patterns of life in conformity with the similar acceleration of the adult world that the adolescent lives in and freely observes. We are fortunate that we have various contraceptive mechanisms available to prevent unwanted teen pregnancy and the unwanted unhappiness that often follows. It would be good for teenagers to use them.

One of the most difficult tasks for the professional is to educate parents in understanding that the use of contraception does not imply a loss of moral standards. It is against the welfare of our young people to insist that there is immorality associated with the use of contraception. Rather, there is practicality, rationality, and a highly *moral* sense of responsibility in not wishing to bring a child that is unwanted into the world. Pediatricians should also point out to the parents of adolescent males and females that it is not irrational to suggest that their sons and daughters always have a condom available when the possibility of sexual intercourse exists. Does this sound like heresy or immoral advice for a physician to give? Hardly. It is vitally important for the pediatrician not to view contraception as a stain on the clean surface of contemporary morality, for if the professional does so, so will the population at large. The contraceptive device is not *causing* something to happen; it is *preventing* something from happening. Both adolescent males and females are responsible for making sure that the two partners are protected during intercourse so that pregnancy or sexually transmitted diseases will not be the unexpected result of their sexual experimentation. Both also are equally accountable for the consequences of their sexual activities. And both must be prepared to supply their own contraceptive devices to assure that they engage safely in their sexual activities.

Because reliable contraception is a necessity for those who are experimenting with sexual activity, pediatricians also are in the delicate and difficult position of helping teenagers decide when they should initiate the use of contraception. It is then important to help teenagers decide how and when to tell their family that they have begun to use contraception. Such communication can be vital in maintaining a supportive emotional atmosphere in the home. However, a realistic approach toward a specific family's attitudes and philosophies must also be taken into consideration. Having taken care of the children for many years, the pediatrician often knows the family well. If it is felt that the young person will be met by a philosophical "brick wall" on issues of sexuality, the pediatrician may wish to support the teenager's freedom of self-decision.

Teenagers, and if possible their parents, must, in addition, be assisted in understanding the various forms of contraception that are on the market today. If the pediatrician does not deal with contraception in his or her office, young patients, with or without their family's permission, can be referred to an appropriate colleague who has both an understanding and compassionate attitude toward teenagers and toward today's sexual scene.

Teenage Pregnancy

There is little question that teenage pregnancy is a serious national problem. Teenagers account for nearly half of the nation's total number of out-of-wedlock births. The pediatrician constantly hears echoed in his ears, "*My* daughter will not become one of those statistics." But, as one who treats pregnant teenagers from all socioeconomic walks of life, my response to such parents is, "Can you be sure?"

There are several reasons why teenage girls become pregnant in this age of increased sexual knowledge and contraception availability. Adolescent girls often spurn the contraceptive pill fearing short-term and/or long-term physical effects and, all too often, do not replace it with another effective contraceptive device. It is the job and responsibility of the pediatrician to offer good counseling advice on the various contraceptive methods, their benefits, and their side-effects.

Pediatricians also must remember that most teenage pregnancies do not result from casual one-night stands between two experimenting adolescents, but are often the result of intercourse between two caring, loving young people. Sexual education notwithstanding, far too many young girls find themselves pregnant because of the sexual extensions of a happy and joyous "steady" friendship. Parents of young girls who are going steady in today's teenage sexual world must be advised that the subject of contraception and prevention of teenage pregnancy should be openly discussed. This is not an invitation to sexual experimentation and/or promiscuity. It is a rational and reasonable approach to a phenomenon which can lead to an unwelcome sexual shock and surprise.

Young girls sometimes become pregnant also as a dramatic means of confronting their parents or as a serious and desparate way of delivering a message to them. Rebellion is obviously the result of a disturbed parent-child relationship in which the daughter feels the need to "punish," "get back at," or "embarrass" one or both of the parents, and nothing rivets a parent's wandering attention to neglected lines of communication like a teenage pregnancy. Rebellious, sexually active teenagers must have contraception. Counseling for the family might be suggested as well.

Once a teenage pregnancy has developed is not the time to begin a sexuality education course—an approach totally out of sequence. The young woman is already pregnant and is, in most cases, well aware of how she became that way. Also, before discussing future methods of prevention, the immediate problem needs to be resolved. A pediatrician may be asked to be responsible for assisting a family in

How to Be a Better Informed Pediatrician

There are several mechanisms by which a pediatrician can gain insight and information about today's changing sexuality in order to be better prepared and informed about the child/teenage populations' intimate human behavior. Some suggestions are:

• **Continue medical education coursework in the area of intimate human behavior.** There is little question that the pediatric specialty is lagging far behind other medical specialties in recognizing human sexuality as a health entity and thus as a necessary part of continuing medical education. Pediatricians throughout the U.S. should initiate a significant number of postgraduate seminars, conferences, and grand rounds in areas which pertain to childhood and adolescent sexuality—from developmental changes to adolescent AIDS. Academic societies, universities, or community hospitals must begin to include these in their continuing education programs.

• **Search the literature for pertinent articles, books and other information materials.** This literature includes pediatric journals, special journals in the field of sexuality, journals of behavioral and social science, as well as the family planning and nationwide information sources on teenage sexuality provided by organizations such as SIECUS and Planned Parenthood. Also, there are increasing numbers of new books available written by authorities in the field of sexuality. Popular trade books by gay men and lesbian women may shed light on related topics, i.e., Randy Shilt's book, *And the Band Played On* on AIDS; and Alex Comfort's, *The Joy of Sex*, offers pictorially what may be difficult to put into words. Also basic texts, such as marriage manuals and sexual therapy guides, can be very valuable in helping the pediatrician relate to the sexual concerns and problems of the young.

• **Gather from young people themselves sexual information about the changing sexuality of today's adolescent.** If pediatricians ask pertinent questions of adolescents and listen carefully to their answers, they will gain tremendous insight into the problems, concerns, and worries that accompany the more open, more experimental, and therefore somewhat more crisis-oriented sexual lives of today's adolescents. To become a good educator, the pediatrician needs to listen, read, and learn with an open mind. New concepts, ideas, philosophies and techniques of sexuality have to be absorbed and considered, receptively, and without bias and prejudgment.

coming to a final resolution of a teenage pregnancy, to act as educator and mediator, and to help expedite and bring about a solution that will be the least painful and most acceptable to all involved. Although the decision-making will be done by the young people involved, with parental assistance, physicians are expected to explain the options—teenage marriage, adoption outside of the family, care within the family or therapeutic abortion—and to discuss their positive and negative aspects.

Cohabitation Before Marriage

On college campuses, twenty years ago, it was considered scandalous for a female and male student to live together. In fact, if they were discovered cohabiting or "living together," they were summarily dismissed. Today, however, the situation is so common that colleges generally disregard the personal living habits of their students. Society at large also is no longer shocked at the phenomenon, although there are many individuals who cannot yet accept it.

Several factors play a significant role with teenagers who reach the decision to live together. They are seeking a close relationship: one that brings them the security of having someone to care for and of having someone who returns their affection; and one that lessens the sexual and social anxiety of the single state. "Living together" cannot be equated, in any way, to their parents' concept of "going steady," for today's young people enter into these early steady relationships with a dedication and an exploration that transcends the comparatively simple going steady memories of their parents. This early sexual bonding is neither a game to be turned off or a phase to be ignored. It is an intense, committed, and often long-lasting state of being together. They also cohabit for other reasons: they do not want the responsibilities of a legal commitment before they have created a solid foundation for their education and careers; and they also have great concern over the high divorce rate of their parents' generation, having watched as their parents argued themselves into divorce or negotiated a sterile, loveless marriage into a cold war. Teenagers, today, fear marriage that results in this type of psychological pain.

To be of real help, the pediatrician needs to understand that the physical commitment of living together can transmute the state of going steady into one in which a true and deep sense of belonging may develop. For some, one hoped-for end result of cohabitation is a soundly based marriage. It is important that young people be counseled that, in living together, they are laying their emotions on the line and that a possible split-up could be as devastating to the one who still cares as separation anxiety is in the

breakup of a marriage, even though there are no legal ties. Cohabiting also can narrow their social sphere, in just the same way and degree as does marriage, at a very important time in their young lives. Sexual education and counseling in the cohabitation situation is preventive pediatrics. Parents must understand that any overt or precipitous actions which alienate the young couple can be very damaging to a future positive relationship between their child, potential son- or daughter-in-law, and themselves. Parental failure to approach this arrangement in a rational, mature way could result in an alienation which might last for many years. Pediatricians must also help parents understand that their children are not their mirror images and that they must accept the very real and, at times, painful realization that what is morally and ethically unacceptable in their lives may not be so in their children's lives.

Homosexuality

For many pediatricians, there is probably no more difficult situation than to be confronted by adolescents who ask for help because of suspected or actual homsexuality. This is the sexual area where many pediatricians fail badly in their ability to reach out and lend a helping hand. This is not surprising, for new knowledge about homosexuality has come so recently that few physicians are well-informed on the subject. Too often, they therefore attempt to eliminate all discussion of homosexuality. Unwilling, afraid, and not concerned enough to deal openly, objectively, and compassionately with this aspect of sexuality, they immediately refer the young person for psychiatric help, without first listening to and evaluating the situation themselves.

Many pediatricians come from a generation taught to repress any possible references to, much less acceptance of, different sexual orientations. Thus, as adults and professionals, they bring to their daily dealings in this sexual area strong biases coupled with naiveté. However, because of the importance of this subject matter to the emotional and physical health and longevity of their patients, pediatricians cannot ignore it if they wish to fill creditable roles as modern professional sexual educators and counselors. Today's young people are deeply into the search for their own identity. They want to know who they are, what they are, why they are the way they are, and what their alternatives are, so that they may make the best choices on their way to adulthood.

Sorenson gives vital data on the occurrence of homosexual experiences among our teenagers.[1] Five percent of 13–15-year-old teenage males have had one or more homosexual experiences, while 6% of the girls in the same age group acknowledged this alternative experimentation. The figure rises sharply to the 16–19-year-age-period for boys, when Sorenson found that 17% have had at least one homosexual encounter. It is interesting to note that the female figure remains at 6%. There is no documentation, however, that this increase in experimentation actually causes an increase in individuals with predominantly gay and lesbian lifestyles. Moreover, past research has indicated that both heterosexuality and homosexuality may be programmed by the age of five.[2]

What can pediatricians do in the way of sexuality education and counseling in regard to homosexuality? Some should admit that they have only the barest of information and the greatest of biases about the subject. This recognition will help them approach investigation of the subject in a realistic and intelligent manner. Also, they should read appropriate texts on the subject and discuss the material with knowledgeable colleagues. When an adolescent reveals his or her homosexual concerns, pediatricians must be intellectually and emotionally prepared. They must remain nonjudgmental and accept the concerns or actions of the teenager at face value. Sheer curiosity may lead the young person to a trial homosexual experience. Most sexual experiences include some degree of intrinsic pleasure. Therefore, the teenager who is in a homosexual panic because of a pleasurable experience must be helped to understand that pleasure does not equate necessarily to orientation nor does a single incident lead to a permanent lifestyle. Some may discover, however, that a same-sex orientation is their predominant desire and may look to the pediatrician for education and guidance.

Pediatricians should be able to speak with youngsters that have homosexual concerns, ask them pertinent questions, and help them to discuss their sexual orientation and the bases of their concerns about homosexuality. It is not necessary, however, to ask about explicit or erotic details or to delve too deeply or intimately; needed information should be obtained without embarrassing or intimidating the adolescent.

It is important to realize that less than 20% of committed homosexuals desire to change; the other 80% want to live comfortably with their chosen lifestlye.[3] Therefore, it is imperative that the physician not place a negative judgment on homosexuality nor suggest that the teenager seek "change" therapy. Despite parental insistence, it must also be emphasized that gay and lesbian persons are no more in need of psychotherapy than heterosexuals. However, if young patients do indicate the need for more counseling, pediatricians should refer them to a psychiatrist or clinical psychotherapist known to deal not only knowledgeably, but also perceptively and sensitively, with this particular issue. Gay and lesbian support groups are also a source of referral for pediatricians.

Parents of homosexual teenagers may require special emotional and educational support in developing the insights they will need to understand their sons and daughters. They can be guided to appropriate reading material to develop greater understanding. Pediatricians can also help parents to be nonpunitive and nonjudgmental and should try to alleviate any guilt they may feel about their son's or daughter's sexual orientation. If the pediatrician can assist parents in seeing their child as a growing young man or woman, who is the same human being as before disclosure, then the pediatrician will have

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"BUT I'M AFRAID TO ASK THE DOCTOR!"

Elizabeth C. Winship

Author of the Nationally Syndicated Column, "Ask Beth"

Hardly anyone likes going to a doctor or a dentist, and adolescents are even more chicken. It's not that teenagers don't need or want medical advice. Although theirs is one of the healthiest times of life, the awesome changes that puberty brings raise all kinds of questions that lead teenagers to write, "I wish I knew if I were normal or not, but I'm afraid to ask the doctor." What a shame, when a quick trip to a physician would probably calm so many fears.

Parents are not always the best ones to give advice to children in their teens. They often try to calm their offspring's anxiety by telling them, "You'll outgrow it. Stop worrying." Few people, especially teenaged people, can stop worrying on command. And waiting may not be the best answer anyway, for doctors nowadays can often help adolescents with problems of complexion, posture, and diet.

Why are kids so scared? We all tend to fear that we will hear bad news. Or that our complaint is so trivial, the physician may label us a complainer or a poor sport. Furthermore, doctors represent authority. Facing authority makes most of us nervous and requires a courage and self-assurance few callow youths possess. It is difficult enough for teenagers to communicate with adults anyway, let alone with authority figures they do not know very well, and who have power over their bodies.

"Bad Girls"

Perhaps the most poignant reason that explains teenagers' fear of the medical profession is that many of their concerns relate in some way to their sexuality.

"I am 13 and my breasts are much bigger than my mother's. All the kids tease me about it, and the boys stare, so I wear a big jacket all the time. I HATE this. I want to go to the doctor but I could never face him. . .Over Built."

It would be terribly embarrassing for this girl even to just talk to a comparative stranger (and usually a male) about this. Imagine the excruciating distress of showing the doctor this intimate part of her anatomy. This is why so many of the kids' questions about too large or too small, too late or too soon, about menstrual cramps or toxic shock or DES go unanswered. Only when the problems become so serious that parents are alerted do many of the poor kids get dragged to the examination table.

The fear of judgment that keeps kids from doctors becomes even more crucial if their problem suggests that the teenager has "done something." That's the main problem in this case:

"I'm 14 and I haven't had my period for three months. I NEVER had sex—I never even went on a date. I'm too scared to talk to boys. But no one will believe me. My friends just give me looks. So I know what the doctor will think. What can I do? He won't believe me either. . .Petrified."

Of course he would believe her—irregular menstrual cycles are the normal state of affairs for most young teenagers, but they don't know that. All they know is that missing a period means pregnancy. They don't want some stranger looking down on them in the assumption they've been "bad girls."

We are all painfully aware that more and more teenagers are becoming involved with sex at ever younger ages. More of them are inevitably developing the need for medical help for pregnancy and sexually transmitted diseases. In these cases, reluctance to seek prompt medical attention is tragic. Enough agencies are available in most large cities to take care of such cases, but far too many teenagers won't risk the scorn or scolding or disclosure they assume will result if they go there. Their problems thus become compounded. A pregnancy test after three months reduces the options, and a sexually transmitted disease untreated risks complications, even sterility.

Statistics prove that pregnancy is not healthy for young teenagers, or their babies, but it is not so much because of the mothers' immaturity as that they do not get adequate medical care for themselves. Young mothers have few or no checkups, and a poor diet, risking a higher rate of toxemia, miscarriage, and other problems, while their babies have a high incidence of low birthweight, which results in mental and physical handicaps.

STDs

Physician-phobia certainly is not primarily responsible for the current epidemic of sexually transmitted diseases, commonly known now as STDs, which comes from vastly increased exposure. Infections that were once relatively rare are spreading like wildfire including herpes and genital warts, which are related to precancerous conditions of the cervix. Gonorrhea, and its look-alike infection, chlamydia, produce no discernible symptoms in more than 80% of

females. It is estimated that between 7,000 and 18,000 women between 15 to 18 years of age become sterile from untreated gonorrhea alone. They are also unwitting carriers of the gonococci. So it matters a lot that young women learn to take responsibility for their sexual health, that is, find courage to go to doctors or public health clinics. Their treatment, by law, is free and totally confidential. But as it is now, millions never go.

Anorexia and bulimia, diseases that are particularly linked to adolescence, are creating havoc in more and more young women and their families. Because one of the basic issues in these eating disorders is that of control between parent and teenager, it is extremely hard to get anorexics or bulimics to go to doctors. Victims adamantly deny that here is anything wrong with them, and just as adamantly refuse medical help until their situation becomes desperate. The refusal to see a doctor is tragic in a disease where the prognosis depends so strongly on early medical intervention.

Another health hazard for modern adolescents is the abuse of drugs and alcohol. While not limited to this age group, substance abuse is harder to treat the earlier the dependency is established. The trouble is that kids have a poor ability to see ahead. It takes 30 or 40 years to develop cancer of the the lung from smoking. What is that length of time to a 14 or 15-year-old? Eternity. But they are unwittingly giving themselves an awful death sentence, as only five out of a hundred victims of lung cancer survive more than five years. Once again, ignorance, denial that there is any problem, and fear of going for help are keeping our kids from getting the medical help they clearly need.

Teenage suicide is a problem that ravages more and more families these days. The number of adolescents who take their own lives has gone up 300% in the last 30 years. Suicide has just surpassed accidents as the leading cause of teenaged deaths. The reason for this tragic situation is not clearly understood. Possible factors are the isolation so many teenagers feel from "the real world," the increase in pressure to achieve, both academically and socially, the big drop in the amount of time parents, especially mothers, are spending with their kids, and fear of the future. Another contributing factor is the failure of adults to recognize the signs of serious depression in young people. Perhaps most important is the special fear kids have of getting psychological help. Seeing a shrink may subject them to the scorn of their peers, one of the worst punishments an adolescent can endure. The answer to the question "Do I need help?" may be overridden by the answer to "What will my friends say?"

Trusting the doctor

What can be done to overcome all this fear? Parents can do a lot to prevent its development in the first place, by exhibiting a reasonable attitude towards doctors in their own lives. This doesn't mean pretending not to be afraid, if you are. It means being truthful about your anxiety, and showing courage in overcoming it, which can turn a negative influence into a positive one.

Parents need to bring up their children to trust and want to consult their doctor. It's essential to see to it that children are treated with compassion and respect from their very earliest visits. If a pediatrician is brusque, aloof, or unsympathetic and doesn't take plenty of time to listen and to explain, switch to a more understanding M.D.

Many young teenagers, even those pretty comfortable with boy- or girlfriends, are mortified to the point of absolute speechlessness in the presence of doctors of the other sex. In adolescence, therefore, it may be wise to find a physician of the same sex as your child.

As children grow, parents need to pay attention to the way they take responsibility for their own health. We usually urge them to do or not do plenty of things where their safety is involved. We don't always teach them how to pay attention to signs that all is not well. We don't want to raise a generation of hypochondriacs, but we do want young people who dare to see a doctor or nurse when necessary. Far better to call for what turns out to be trivial, than to fail to call for something that is potentially serious.

Doctors themselves can do a lot to smooth the way for adolescent patients. Some clever and experienced doctors and nurses know how to broach the more ticklish subjects, enabling their young patients to bring up their most intimate concerns. The essential ingredient is privacy, which for this age group mostly means not involving the parents. So doctors need to be able to speak to the kids alone, and involve the parents only if the patients agree, or if it is a very serious matter. Doctors need to be forthcoming in offering information and discussing possibilities concerning the patient's symptoms, and to do this in language the teenagers can easily understand. And lastly, the doctor must be relaxed, interested, calm, and nonjudgmental.

Little is taught in medical schools about patients' fears, embarrassment, depression, or any other problems of emotions, or problems about sexuality. Doctors and nurses are in a wonderful position to educate the young about their health, and especially about their sexual health, particularly right now, since so many parents, schools, and churches are unable to help very much.

Too many of our kids suffer needlessly from a failure to seek prompt medical attention. They pay in terms of their health and happiness, and society pays in terms of the expensive consequences of teenage pregnancy, Aid For Dependent Children of teenage parents, skyrocketing sexually transmitted disease and substance abuse. The price is exorbitant. Prevention would surely be cheaper. A great deal of suffering and waste could be eliminated with a sensitive and forceful campaign to help our teenagers get themselves into the doctor's office.

Elizabeth C. Winship is a member of the SIECUS Board of Directors.

In the Executive Director's Opinion . . .

Human Sexuality Education: Whose Job Is It Anyway?

Debra W. Haffner

When I talk with reporters, the question I am most frequently asked is, "Whose responsibility is it to educate children about sexuality?" The heart of much of the controversy surrounding sexuality education rests with that question. Is it the parents' job? Is it the schools' job? What about the churches?

The lead articles in this month's *SIECUS Report* emphasize the important role that medical providers can play in providing sexuality education to children, their parents, and older adults. Clearly medical providers can help set the tone for parent-child communication about sexual topics by modeling open, straightforward communication during exams and consultations. The fact that a majority of private practitioners report that they would be unwilling to provide an adolescent with contraceptives without parental consent indicates that we have a long way to go in educating these providers on their important role. And certainly training programs for physicians, nurses, and other allied health professionals need to include coursework in human sexuality.

It has been axiomatic among sexuality educators for some time that "parents are the primary sexuality educators of their children." There is no question that parents of small children provide the initial messages, values, and ideas about sexual issues, including touching, gender identity, intimacy, bonding, relationships, etc. We model our beliefs about sexuality on a daily basis, and our children live in the world we create.

I think I was more glib about the ease of parents being the sexuality educators of their children *before* I had a child. As I taught workshops for parents, I was able to model planned appropriate communication in response to the "oh no!" situations. Somehow it is much more difficult to respond calmly and assuredly to my three-year-old's questions. I am often struck when I am stumped by her comments, the most recent one when we were together in the car: "Daddy said I used to be swimming inside him before I got to your uterus." How difficult these situations must be for parents who do not have the benefit of training, workshops, and journals!

I have also been struck recently by how little control parents have over their child's sexual education once the child enters the world of school and playmates. My daughter came home from a playmate's this weekend quite puzzled, "Hal says that I can't play with all of his toys, because they are boy toys." My explanation that there is no such thing, that she can play with whatever she chooses, did not help her hurt feelings. And I know that this is only the very beginning of messages and ideas about sexuality that are out of our control.

Many parents report that they are uncomfortable in the role of providing even factual information about sexual topics to their children. Most want additional support. Although almost all parents want to do a better job of telling their children about human sexuality than did their parents, they also almost universally ask for assistance when it is available. In fact, over 90% of parents want schools to provide sexuality education.

And yet, schools alone cannot handle the burden of providing sexuality education to our children. As noted in the last *SIECUS Report*, more schools than ever before are providing some type of sex education. And yet the response is often too little and too late. Further, schools are hampered by competing priorities for limited time. Less than 10% of young people are receiving comprehensive sexuality education through their schools.

SIECUS advocates the delivery of comprehensive, age appropriate, school-based sexuality education for children at all grade levels. These programs should be developmentally appropriate and include such issues as self-esteem, family relationships, parenting, friendships, values, communication techniques, dating, and decision-making skills. Programs must be carefully planned by each community in order to respect the diversity of values and beliefs present in a classroom.

Religious organizations clearly have a major role to play in the sexuality education of our children. It is to religious institutions that millions of families turn for guidance

about values and ethical issues, and it is clear that sexual issues should be included in the religious education of our children. Several major denominations, including Methodists, Presbyterians, Conservative Jews, and Unitarians have taken the lead in promoting religious education about sexuality.

Further still, youth-serving agencies have a major role to play in sexuality education. Millions of young people are enrolled in programs run by such agencies. The national Boys Clubs has an excellent program aimed at young teen males called Smart Moves. The Girls Clubs is piloting a comprehensive approach to teen pregnancy prevention, starting with an abstinence program, Will Power, Won't Power, aimed at the youngest girls and a program connecting health services to education aimed at the oldest. Other youth-serving agencies, such as the YWCA, Camp Fire Girls, and the Future Homemakers of America also have excellent programs.

Perhaps the most ubiquitous sexuality educator of our children is the media. Every day, our children are exposed to countless messages about sexuality through television, advertisements, movies, and music. One afternoon of watching MTV provides countless exploitative messages about gender roles, intimacy, sex, and violence. A survey released in 1985 found that the average American television viewer is exposed to over 20,000 implied sexual acts and sexual innuendo in one year of watching television. I often encourage parents and professionals to watch one afternoon of *General Hospital* or MTV to learn about their teenage child's sexual education.

Yet clearly all media messages are not harmful. Warner Brothers has recently produced a series of AIDS prevention public service announcements featuring its recording artists. And television programs such as *21 Jump Street, Designing Women, and L.A. Law* have all dealt honestly and movingly with sexual themes.

The government, too, has a role in the sexuality education of our children. Official messages during the last administration told our children to "just say no" regardless of the consequences. We can only hope that the new administration will take a more realistic look at the needs of our children and youth. Clearly there needs to be increased funding for school health and AIDS education, there needs to be a federal office on sexuality education focusing on these issues, and there must be adequate support for family planning, prenatal care, and medical services.

The point is that sexuality education is not any single sector's job or responsibility. A 1987 demonstration study in South Carolina found that a coordinated community response was able to lower teenage pregnancy rates. Other studies of single interventions have shown that single interventions alone are unlikely to influence behaviors.

The answer to the question, "Who's job is it anyway?," is that it is all of ours. Parents, schools, churches, youth groups, the media, government agencies—indeed all those who influence our children's world—must become involved in helping our children grow into sexually healthy adults.

MARCH FOR WOMEN'S EQUALITY/ WOMEN'S LIVES

APRIL 9, 1989 WASHINGTON DC

SIECUS is co-sponsoring this national demonstration to support reproductive rights. Come show your support for keeping abortion safe and legal.

SIECUS' delegation will convene at 10 a.m. We will march under a SIECUS banner. Call Julie Sperling at 212-673-3850 for more details.

Conference / Seminar Calendar

CHILDREN'S DEFENSE FUND CONFERENCE, "LEADERSHIP FOR CHILDREN IN A NEW ERA," *March 8-10, 1989,* will focus on what works and how to make it work better in adolescent pregnancy prevention, health, child-care, education, youth employment and training, child welfare, housing and homelessness, etc. The Sheraton Washington Hotel, Washington, DC. Contact: Children's Defense Fund, 122 C Street NW, Washington, DC 20001, 202/628-8787.

INSTITUTE FOR BEHAVIORAL MEDICINE WORKSHOP, "SILENT SHAME: THE PATH TO ADDICTION," featuring Dr. Patrick Carnes, will focus on how sexual addiction occurs in individuals and on strategies that professionals can use to assist clients in their recovery. It will be held in Milwaukee, *March 8-9, 1989;* Boston, *March 10-11, 1989;* Phoenix, *April 5-6, 1989;* San Francisco, *April 7-8, 1989.* Contact: Diane Campbell, Workshop Coordinator, 3920 Woodview Court, St. Paul, MN 55127, 612/484-8090.

14TH ANNUAL REGIONAL ADOLESCENT SEXUALITY CONFERENCE, "MATURING AS HEALTHY AS POSSIBLE," *March 9-10, 1989.* Sponsored by the Marion County Health Department in cooperation with the U.S. Public Health Service, Region X, Seattle. More than 500 professionals, from schools, health departments, and public and private agencies, are expected to attend. Will cover a broad range of topics, with emphasis on sexuality education and adolescent health concerns. Keynote speaker is Dr. Jesse Potter. Chumaree Hotel and Convention Center, Salem, Oregon. Contact: Kristin Nelson, Marion County Family Planning, Health & Human Services Building, 3180 Center Street NE, Salem, OR 97301-4592, 503/588-5355.

SEX EDUCATION COALITION, SKILL BUILDING WORKSHOPS 1988-1989, SAR TRAINING PROGRAM, "Homosexuality: Youth and Family" with presenter Wayne Pawlowski, ACSW, *March 15, 1989.* Co-sponsored by the Sexual Minority Youth Assistance League. Council of Governments Headquarters, Washington, DC. **"Sexual Attitude Reassessment: The Critical Training Experience for All Sex Educators"** with presenters Pamela Wilson, MSW, and James C. Achtzehn, PhD, *April 15-16, 1989.* The National 4-H Center, Chevy Chase, Maryland. **"Sexuality Education for the Developmentally Disabled"** with presenter Frank Caparulo, MS, *April 26, 1989. Gallaudet College, Washington, DC.* **"SEC Annual Media Fair,"** *June 21, 1989.* Prince George's Community College, Largo, Maryland. Contact: Sex Education Coalition, 2001 O Street, NW, Washington, DC 20036, 202/457-0605.

16TH ANNUAL RESEARCH MEETING OF THE SOCIETY FOR ADOLESCENT MEDICINE, *March 19-22, 1989.* Will include paper and poster presentations; the J. Roswell Gallagher Lectures with the theme "Visions for Youth"; workshops and roundtables (a number of them will focus on adolescent sexuality issues); special sessions and events. Hyatt Regency Hotel, San Francisco, California. Contact: National Abortion Federation, 900 Pennsylvania Avenue SE, Washington, DC 20003, 202/546-9060.

11TH NATIONAL LESBIAN AND GAY HEALTH CONFERENCE and 7TH NATIONAL AIDS FORUM, "OUR COMMITMENT FOR THE 90'S: REFINING OUR AGENDA," *April 5-9, 1989.* The overall goal of the conference is to continue to formulate a health care agenda for the next decade. Programming will be strong in three key areas: lesbian health care; gay male health care; and AIDS and HIV-related disease. Sponsored by the National Lesbian and Gay Health Foundation and The George Washington University Medical Center. (1500 people are expected to attend.) Cathedral Hill Hotel, San Francisco, California. Contact: Greg P. Thomas, The George Washington University Medical Center, Office of Continuing Medical Education, 2300 K Street NW, Washington, DC 20037, 202/994-4285.

HARVARD MEDICAL SCHOOL DEPARTMENT OF CONTINUING EDUCATION, "THE PSYCHIATRIC TREATMENT OF ADOLESCENTS AND YOUNG ADULTS," *April 7-9, 1989.* Sponsored by the Department of Psychiatry, Massachusetts General Hospital, under the direction of Ned H. Cassem, MD; Michael S. Jellinek, MD; David B. Herzog, MD; and Eugene V. Beresin, MD. "This course will cover: diagnosis and treatment of depression, suicide, drug and alcohol abuse, schizophrenia, eating and anxiety disorders; violence and antisocial behavior; sexuality and AIDS; and prevention strategies for adolescents at risk." Copley Plaza Hotel, Boston, Massachusetts. Contact: Harvard MEDCME, PO Box 825, Boston, MA 02117, 617/732-1525.

"AIDS, MEDICINE & MIRACLES: A MULTIDISCIPLINARY DIALOGUE FOR CARE GIVERS, POLICY MAKERS AND PEOPLE LIVING WITH HIV INFECTION," *April 27-30, 1989,* "takes a positive stance and seeks to discover the unifying aspects of diverse perspectives. This is a forum for an array of expert opinion and for the presentation of documented research results. An important aspect of the conference is the inclusion of people with HIV infection, who will add their own expertise. This conference is a practical demonstration that 'we are all living with AIDS.' We can all contribute to the discussion about ways to realize our hopes and goals for wellness." Clarion Hotel, Boulder, Colorado. Contact: AIDS, Medicine and Miracles, Inc., 2033—11th Street, Suite 1, Boulder, CO 80302, 303/447-8777.

UNIVERSITY OF KENTUCKY, COLLEGE OF HOME ECONOMICS, NATIONAL CONFERENCE, "SINGLE PARENTS AND SELF-SUFFICIENCY: IMPLICATIONS FOR WELFARE REFORM," *June 22-24, 1989.* The conference is being designed to attract researchers, program administrators, and policymakers. Sessions will include scholarly research, discussions of programmatic issues, and presentations by nationally known speakers. Conference proceedings, including copies of all papers, will be distributed at the conference. Radisson Plaza Hotel, Lexington, Kentucky. Contact: Donna A. Hall, Director of Special Programs, 204 Frazee Hall, University of Kentucky, KY 40506-0031, 606/257-3929.

WHAT DOCTORS AND OTHERS NEED TO KNOW

Six Rules on Human Sexuality and Aging

Richard J. Cross, MD

Certified Specialist in Internal Medicine,

Professor Emeritus at the Robert Wood Johnson Medical School, New Jersey

Most of us find that our definition of old age changes as we mature. To a child, anyone over forty seems ancient. Sixty-five and older is the common governmental definition of a senior citizen, and it is the definition that I will follow here, although the author who is 73 long ago found it not entirely acceptable. There is, of course, no specific turning point, but rather a series of gradual physical and emotional changes, some in response to societal rules about retirement and entitlement to particular benefits.

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

The Six Rules

In my opinion, the care of the elderly could be significantly improved if doctors and other health workers would remember and apply the following six, simple, basic rules:

1. All older people are sexual.

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

How many older people are sexually active? In an admittedly somewhat biased sample, Ed M. Brecher reported in *Love, Sex, and Aging,* (Little, Brown and Company, 1984) that the proportion of both males and females who are sexually active declines, decade by decade, ranging from 98% for married men in their 50s to 50% for unmarried women of 70 and over. At each decade, there are also some people who are inactive. It is important to accept abstinence as a valid lifestyle as well—at any age—as long as it is freely chosen.

2. Older people have a particular need for a good, sexual relationship.

To a varying extent, the elderly experience and must adapt to gradual physical and mental changes. They may find themselves no longer easily able to do the enjoyable things they used to do; their future may seem fearful; retirement and an "empty nest" may leave many with reduced incomes and no clear goals in life; friends, and/or one's lifetime

partner, may become ill, move away, or die; and the threat of loneliness may be a major concern. Fortunately, most older people are not infirm, frustrated, fearful, poor, bored, and lonely but, nonetheless, some of these elements may be affecting their lives. An excellent antidote for all is the warmth, intimacy, and security of a good, sexual relationship.

3. Sexual physiology changes.

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

Older men commonly find that their erections are less frequent, take longer to achieve, are less firm, and are more easily lost. Ejaculation takes longer, is less forceful, and is smaller in amount. The refractory period (the interval between ejaculation and another erection) is often prolonged to many hours or even days. The slowing down of the sexual response cycle can be compensated for simply by taking more time, a step usually gratifying to one's partner, especially if s/he is also elderly. But in our society, many men grow up believing that their manliness, their power, and their competence depend on their ability to "get it up, keep it up, and get it off." For such an individual, slowing of the cycle may induce performance anxiety, complete impotence, and panic. Good counseling about the many advantages of a leisurely approach can make a world of difference for such an individual.

The prolonged refractory period may prevent a man from having sex as often as he formerly did, but only if he requires that the sex act build up to his ejaculation. If he can learn that good, soul-satisfying sex is possible without male ejaculation, then he can do it as often as he wants.

Finally, many men (and sometimes their partners) need to learn that wonderful sex is possible without an erect penis. Tongues, fingers, vibrators, and many other gadgets can make wonderful stimulators and can alleviate performance anxiety.

Some women find the arrival of menopause terribly depressing; others feel liberated. If one has grown up in a society that believes that the major role for women is bearing children, then the loss of that ability makes one feel no longer a real woman.

The most common sexual problems of older women, however, is atrophy and drying of the vagina, which can make intercourse uncomfortable and painful, particularly if her partner is wearing an unlubricated condom. The obvious, simple solution is to use one of the many, water-soluble lubricants that are available at drugstores. Saliva is a fairly good lubricant and it does have four advantages over commercial products: 1) It is readily available wherever one may be; 2) It is free; 3) It is at the right temperature; and 4) Its application is more intimate than something from a tube.

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

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

4. Social attitudes are often frustrating.

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

Some have suggested that the best way for an older woman to find a sex partner is to become a lesbian. Few, however, have successfully made this transition and for many, homosexuality is completely unacceptable.

When doctors see an older woman, they can, at the least, inquire about the possibility of sexual frustration and, if it is present, be understanding. Some women can be encouraged to try masturbating, and some will find a vibrator a delightful way to achieve orgasm.

Older people are living in a variety of retirement communities and nursing homes. This brings potential sexual partners together, but tends to exaggerate the gender imbalance. In retirement "homes," single women often outnumber single men, eight or ten to one. Furthermore, rules, customs, and lack of privacy severely inhibit the establishment of intimate relationships. Administrators of such homes are often blamed for this. Some are, indeed, unsympathetic, but we must also consider the attitudes of the trustees, the neighbors, and the legislators who oversee the operation, and particularly the attitudes of family members. If two residents establish a sexual liaison, it is often followed by a son or daughter pounding the administrator's desk and angrily shouting, "That's not what I put Mom in here for!" In the immortal words of Pogo, "We have met the enemy, and they are us."

5. Use it or lose it.

Sexual activity is not a commodity that can be stored and saved for a rainy day. Rather, it is a physiologic function that tends to deteriorate if not used, and it is particularly fragile for the elderly. If interrupted, it may be difficult (though not impossible) to get restarted. Doctors should work with the patient and partner on reestablishing the relationship, if that is desired.

6. Older folks do it better.

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

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

Dr. Richard J. Cross is a member of the SIECUS Board of Directors.

(Continued from Page 8)

made great strides in maintaining the wholeness of one family and in practicing good preventive pediatrics.

Conclusion

The pediatrician has an obvious and possibly major role to play in sex education and counseling. This role can be performed in the office, in schools, in the community, with boards of education, on boards of such health organizations as SIECUS or Planned Parenthood and their respective affiliates, and within pediatric academic societies. In each of these areas, the pediatrician must act as a catalyst to bring to the fore the need for intelligent and sensitive sexual education for professionals, parents, and the community as a whole.

The pediatrician, in all ways and at all times, must be a sexuality educator of the individual child and his or her parents. Here, he or she has the role of transmitting facts, discussing problems, and giving advice. However, the one area of sexual education which, very likely, is of greatest significance is the ability to transmit to both parent and child/teenager what should be the ultimate goal in an individual's well-adjusted sexuality: responsibility for oneself; responsibility for the other person; and responsibility to the society. This should always be the focus for the pediatrician's long-range goals with all children and their parents. If children can be taught through action, education, and inference that they must always take into consideration—when confronted with sexual problems and decisions—their responsibility to themselves, their responsibility to the other person, and their responsibility to the moral and legal laws of society, they will be much better prepared to cope with life as well-adjusted sexual adults.

In our modern world, sexuality is a vitally important aspect of pediatric practice. Intimacy between human beings is at the core of successful living. The pediatrician must not, cannot, and should not be anything less than a leader in this area.

Footnotes

1. Sorensen, R.C. *Adolescent sexuality in contemporary America.* New York: World Publishing Times Mirror, 1973.
2. Green, R. & Money, J., eds. *Transsexualism and sex reassignment.* Baltimore: The John Hopkins Press, 1969.
3. Remafedi, G. Male homosexuality: The adolescent's perspective. *Pediatrics,* 1987, 79(3).

Dr. Kappelman recently received the Richard J. Cross Award for Distinguished Contributions to Sexuality—from the Department of Environmental & Community Medicine of the University of Medicine and Dentistry of New Jersey—in recognition of his outstanding work in the field of adolescent sexuality and for the teaching of the humanities in medical school education. "His unique approach to teaching and clinical practice has consistently defined him as an exemplary physician and educator: competent, knowledgeable, empathetic and caring." The award is named after SIECUS Board Member Richard J. Cross.

SIECUS News . . .

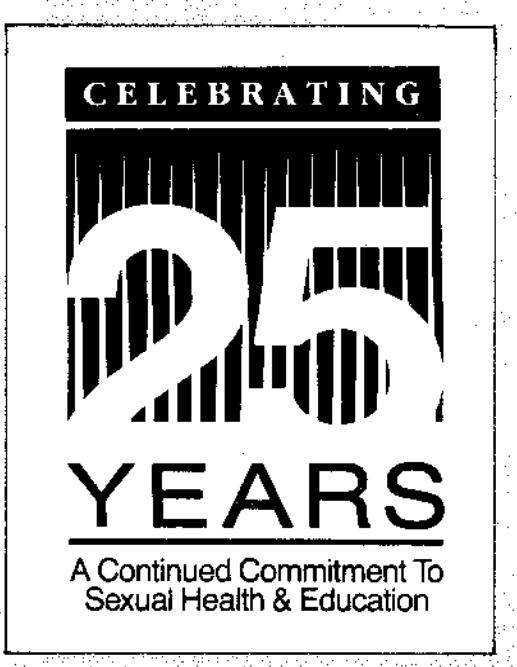
FAll 1988 was a very busy time for the SIECUS staff. This new bimonthly column will keep our members up-to-date on our activities.

MANPOWER DEVELOPMENT RESEARCH CORPORATION: SIECUS has received a subcontract from the Manpower Development Research Corporation (MDRC) to provide research on curriculum and program design. MDRC has initiated a new project, New Chance, directed to older parenting adolescents. SIECUS staff, under the direction of Director of Program Services Diane de Mauro, will be reviewing existing family life and vocational education curricula for MDRC and offering recommendations on the development of new program models for this target population.

LEARNING LINK: SIECUS has developed an exciting new computer-based program in conjunction with WNET TV, the New York based station of the Public Broadcasting System. WNET has placed Learning Link computers in 500 schools (with five people at each site) and 100 libraries and other institutions in the New York metropolitan area and in 50 schools and institutions nationwide. Teachers and students in these schols will have access to SIECUS materials and resources simply by logging on to this computer. SIECUS staff will be available to consult with teachers as they design their family life education programs. In addition, students will be able to ask the computer questions about sexuality and receive confidential answers.

25th ANNIVERSARY: SIECUS began its 25th anniversary celebration in January. The March/April issue of the *SIECUS Report* will be a specially designed historical issue which will look at the history of sexuality and sexuality education over the last twenty-five years. A special 25th anniversary event is planned for April 27, 1989 from 6:00 p.m. to 8:00 p.m. at the Grey Art Gallery, New York City. All SIECUS members in the New York metropolitan area will be invited; if you are planning to be in New York at that time, please let us know and we will send you an invitation.

LIBRARY: The SIECUS library is open from 10:00 a.m. to 8:00 p.m. four evenings a week and from 9:00 a.m. to 1:00 p.m. on Friday. Under the direction of SIECUS Librarian Daniel Donahue, the library staff is available to assist you with research questions, statistical information, computer searches, and resource suggestions. Plan to visit the SIECUS library during your next trip to New York or call the library staff for assistance on your next project.



EXECUTIVE DIRECTOR TRAVELS: SIECUS Executive Director Debra Haffner has been on the road promoting sexual education and AIDS education. In recent months, she has participated in strategy meetings held at the National Academy of Sciences, the National Federation of State High School Associations, and the Alan Guttmacher Insititute. During the fall of 1988, Ms. Haffner spoke to more than 1500 professionals at conferences sponsored by the American Public Health Association, the Boston Public Schools, Sloan Kettering Memorial Hospital, and Planned Parenthood of Bergen County.

NEW PUBLICATIONS: SIECUS has planned a busy publication schedule for this winter and spring. We will be publishing an updated version of our popular pamphlet, "How To Talk To Your Children About AIDS," in late winter, which will include up-to-date information and new resources. The revised version will be written at a 6th grade reading level. SIECUS' annual report will be available in February 1988; members may request a complimentary copy. Also, a new publication catalog will be sent to all SIECUS members in February.

SIECUS STAFF

Debra W. Haffner, Executive Director
Diane de Mauro, Director of Program Services
Daniel Donahue, Librarian
Janet Jamar, Director of Publications
Christine Sperry, Financial Manager
Raquel Burgos, Membership Coordinator
Jeanette Reyes, Membership Assistant
Julie Sperling, Office Coordinator
Mark Bigler, Graduate Assistant

THE NEW FAMILY LIFE AND HUMAN SEXUALITY TEXTBOOKS

For Junior and Early Senior High School Age Groups

Konstance McCaffree, PhD

Faculty, Graduate School of Education, Human Sexuality Department, University of Pennsylvania and Council Rock High School, Newtown, Pennsylvania

There was an influx of family life and human sexuality textbooks for the junior and early senior high school age groups in 1987–1988. Prior to this, publishing companies preferred to produce general texts with human sexuality supplements for the few schools who asked for them. The following is a review of the most widely promoted of these new books.

HUMAN SEXUALITY by Elizabeth Winship, Frank Caparulo, and Vivian K. Harlin, MD. Houghton Mifflin Company, 1988 (158 pp.; student's edition, $13.32, teacher's edition, $16.60).

Human Sexuality has received some publicity because of the popularity among teenagers of one of its authors, Beth Winship. Winship's nationally syndicated column, "Dear Beth," is read by a cross section of the teen population. The question and answer format that she uses for her column has also been used as an effective introduction to each of the nine chapters of this educationally well-designed paperback textbook. Each question is succinctly answered in bold print. The first few questions were seemingly written by young female teens, and I was initially concerned that the book would be more appealing to young women. However, the authors have made an obvious attempt, throughout the book, to include men, some ethnic groups, and all ages of sexual beings in the text and in the pictures.

The concise chapters—Male and Female Roles; Puberty; Dating; Sexual Behavior; Sexual Health Care; Sexually Transmitted Diseases; Family Life; Pregnancy and Birth; and Problems of Sex in Society—are divided into short lessons with review questions after each lesson. Each of these includes a chapter review, which is comprised of a vocabulary lesson and a set of review and discussion questions. Scattered throughout each chapter are headings and vocabulary, highlighted in red, and ideas for further investigation by the students. Young teenagers and poorer readers will find this book generally easy to utilize because the sections are short and there are pictures or diagrams on almost every page.

It is difficult to interest young men in contraception information because, in most cases, they have been involved only with the condom. Information about contraception is included in the chapter on sexual behavior and, although it refrains from language that would suggest that it is up to the woman to abstain, the text would have been enhanced tremendously by offering suggestions about how men can be included in the use of various contraceptives and/or by pictures, for example, showing a man purchasing contraception or being a supportive partner when visiting a doctor's office. The chapter is also particularly weak in providing information on how a young person can be helped to overcome the handicaps which are present for all youth in obtaining contraception after the decision has been made to have intercourse and to avoid pregnancy.

Homosexuality is discussed in the chapter on sexual behavior—and not, fortunately, in the chapters which focus on sex in society or sexually transmitted diseases! The section, however, is very brief and attempts to provide only *one view* on what some doctors believe causes homosexuality, although the sentence before the description in the book states that "No one knows exactly why." Also, at the end of the chapter, the review question asks only "What is homosexuality?" even though the chapter discusses some of the myths associated with homosexuality; attempts to point out how society has been discriminatory; and to show the similarity of gay and lesbian relationships and feelings to heterosexual friendships, dating, and loving relationships. The section includes a picture of "Gay/Lesbian Pride Day" which is important for young people to see. Also, the chapter on dating is heterosexist. It assumes that all attraction is for the "opposite" sex. The

authors could very easily have made the language more generic and been inclusive of the youth who is feeling same sex attractions. Same sex attraction is explained as being natural and "normal," but only in the context of the stage the young person is going through. It is explained away as a crush and "a way of practicing for more mature relationships." This crush is then described as fading "when you form real friendships with members of the opposite sex."

The chapter on sexual health care is brief, yet inclusive, of topics such as regular checkups for both young women and men, breast and testicular self-examination, premenstrual syndrome (PMS), toxic shock syndrome (TSS), inguinal hernias, torsion, pelvic inflamatory disease (PID), and more. However, teachers will need a good background on these subjects in order to answer the many questions this section may generate.

This text also makes the same mistake that many books do when discussing sexually transmitted diseases. It describes causes and symptoms of several diseases and then begins with gonorrhea and syphilis, instead of chlamydia, herpes, and venereal warts, which are much less known but higher on the list in incidence. There is a section on preventing and treating STDs, but it is very small and placed at the end of the chapter. Also, there is no help for young people on the troublesome aspects of how to talk to a partner about preventing the sharing of diseases nor is there any discussion of the attitudinal and emotional issues which limit a teen's ability to believe that "It could happen to me."

I was excited to see a chapter which included a discussion of prostitution, pornography, date rape and rape, sexual abuse of children, and more. It was disheartening, however, to see transvestites and transsexuals included under the chapter subsection entitled "Misuses of Sexuality." The authors' values are also clearly stated when child molesters are labeled as "pedophiles" which not all child molesters are; prostitutes are described as living a "harsh and cruel life that destroys a person's dignity"; and voyeurs are described as "abnormal." Other values or explanations of the ways our culture encourages these behaviors—despite holding negative views about them—are not included. A section is included on the media and its influence on our beliefs, but it does not discuss the ways in which the media might be encouraging viewers to be voyeurs on some level.

Though this text is a good educational tool for young people, educators need to be aware of the biases which are inherent within it. The most glaring omission is the sexuality of the disabled. There is no inclusion of a young disabled person—either in the text or in the pictures—who has the typical feelings of a teenager but the additional concern of acceptance and belonging when he or she may be more different than other teens.

There is an accompanying teacher's edition which provides the facilitator with some valuable support. A brief rationale for each chapter is included; behavioral objectives; hints on how to approach some of the topics; resources, which may be an asset to instruction, in the form of potential speakers, modern films (and how to order them), and additional reading; and a discussion of the answers to all review questions and vocabulary usage. Throughout the teacher's edition of the student textbook additional information is provided which could have been included in the text. Presumably, it was considered more helpful when added by the teacher than as cumbersome reading for the student. **C, ET, LT**

FAMILY LIFE AND HUMAN SEXUALITY by Beverly K. Biehr, Vivian Gunn Morris, Jon Colby Swanson, and Patrick K. Tow. Orlando: Harcourt Brace Jovanovich, 1987 (122 pp.; student's edition, $7.65, teacher's edition, $14.40).

Family Life and Human Sexuality resembles the former text in its size and shape and in its emphasis on the educational strategies that are provided throughout the chapters. In addition to the chapter's content, the authors have added intermittent Section Reviews and a Chapter Review which includes a summary; a list of the chapter's key terms with page number identified; a quiz; and suggestions for further reading. They also offer a complete glossary and index for aiding the student in finding topics.

In comparing this text to the previous one, there are two distinct differences in format. One is the inclusion, throughout the text, of a Myth/Fact sidebar—which selects a popular myth, such as "A woman cannot get pregnant the first time she has sexual intercourse," and presents the correct fact—and the Case Study, which includes discussion and application questions for use by the teacher in involving students more personally in the content of each chapter.

The emphasis of this textbook is slightly different from the first as well. The chapter on family deals with family structure and the factors which influence family relationships, and it does not deal with marriage, teen pregnancy, and abortion as family issues. These are discussed in other chapters.

There is a complete chapter on "Understanding Yourself and the Opposite Sex" which could have discussed males and females as friends, but assumes only opposite sex attraction and how this attraction influences relationships. The text also is very weak in looking at dating issues except when intercourse is involved in a relationship.

The chapter on "Care of the Reproductive Systems" includes only the most prevalent STDs and emphasizes the prevention and treatment of the diseases rather than spending valuable reading time on too extensive biomedical description of every disease that is possible. It also includes self-examinations, but does not include a picture of description of a breast self-

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

examination although it does include one of a testicular examination. The authors also do not encourage young men to get a complete physical examination, stating that "men after 40 need . . . [them] more frequently." The "Family Planning" section of the chapter divides methods into chemical, physical, surgical, and natural; explains how to obtain them; and discusses the effectiveness and risks of birth control.

Most of the situations described in the text are those of the middle class, two-parent family. And throughout, discussions of most topics—especially of marriage, parenting, love, etc.—have heterosexual assumptions. Homosexuality is included briefly as a topic and the authors have chosen not to discuss feelings, life issues or explanations. The text includes no information on varied lifestyles and provides minimal discussion of gender roles and the influence of stereotyping on our attitudes and behaviors. In the section on sexual behavior, rape and sexual abuse are described, and it is emphasized that neither is the fault of the victim, which is good. Pornography, a controversial topic, is included as a sexual influence and source of "unreal and irresponsible" information for teenagers.

The *Teacher's Edition*, which accompanies the student textbook, is not as helpful as the one provided for the first text. However, it does include Chapter Objectives, a Motivating Activity, Teaching Suggestions, and a Challenge Activity, which teachers will appreciate. But, with the exception of the chapters entitled "Pregnancy and Birth" and "Family Planning," which offer more supplementary information, no additional help is given to teachers throughout the content of the chapters. The only answers provided in this textbook for teachers are those related to the Case Study and Quiz sections. Most helpful for teachers is the inclusion of a set of copy masters: copy master handout material is provided on breast self-examination, testicular examination, TSS, PMS, medical procedures of abortion, rape, sexual abuse and child abuse, birth control, fetal development, and the birth process.

This text is concise and provides very basic information for students and teachers, but educators will need more background information than is provided. Students, however, will not need to struggle though a difficult text in order to find definitions. **C, ET**

FAMILY LIVING AND SEX EDUCATION by Marcia Scott, MD. New York: Globe Company, 1988 (125 pp.; student's edition, $4.79, teacher's edition, $1.80).

In contrast to the above two textbooks, *Family Living and Sex Education* does not provide an educational format helpful for the students or the teachers who might use the book. The book is also a paperback and might be improved if the pictures were of better quality. However, each section of the chapters does include a summary statement and does end with brief sections entitled Checking Up, Thinking It Over (labeled with a male/female symbol), and Understanding Yourself. A positive feature of each chapter is the inclusion of a highlighted, one-page, in-depth description of an interesting topic. In "The Body Grows Up," the description of "The Truth About Masturbation" is much more inclusive than either of the other two texts. It provides students with a definition and discusses the pleasures, myths, and reasons why people are sometime negative about masturbation.

In the chapter, "The Changing Family and Sexuality," the authors have chosen to focus on teenage marriage and parenting without including any information on many of the variations of lifestyle seen today. And, in the chapter entitled "Sex and Society," the authors include sex and the law, rape and sexual assualt, sexual abuse of children, *and homosexuality* which does not belong there. Each of the book's chapters also tend to focus on the sexual issues in relationships. For example, in "Sexuality in Your Social Life," after discussing the importance of saying how one feels and naming one's emotions, the authors deal only with sexual intercouse and saying "no" to sexual activity. They do not include information on dating, love, friendships or on sex role stereotyping, to name a few topics.

Chapter 11, "Where to Find Help," however, is far more inclusive than the other two texts in the information given to students on obtaining help from other places outside of the family. **C, ET**

BOOK BRIEFS

LETTERS TO JUDY: WHAT YOUR KIDS WISH THEY COULD TELL YOU
Judy Blume. A Kids Fund Project. New York: G.P. Putnam's Sons, 1986 (284 pp., $17.95).

"The letters in this book offer an intimate look at kids today—kids speaking in their own voices about their own worries, their concerns and their relationships with friends and family. . . .Kids write to me about their most intimate concerns, often prompted by the experiences of the characters in my books."

MARITAL THERAPY: AN INTEGRATIVE APPROACH
William C. Nichols. New York: The Guilford Press, 1988 (282 pp., $30).

This book is intended for those who wish to learn about marital therapy and to improve their understanding and skill in dealing therapeutically with married couples. The chapter on marital sexual problems covers sexual abuse, incest, medication and sexual response. Other issues, such as extramarital affairs, marital violence, and alcohol problems are also discussed in the book.

WOMEN'S MOVEMENTS OF THE WORLD: AN INTERNATIONAL DIRECTORY AND REFERENCE GUIDE
Sally Shreir (ed.). United Kingdom: Keesing's Publications, Longman Group UK Limited, distributed by Oryx Press, Phoenix, Arizona, 1988 (384 pp., $95).

A guide to the current status of women's issues and organizations throughout the world, organized alphabetically by country. Includes a short section on international organizations and a select bibliography. Introductory sections for each country provide information on topics relating to the context within which women's groups operate: women's participation in political life, the workforce, education, their rights within marriage and at divorce, laws and practices relating to contraception and abortion. Listed are women's councils, associations, federations, bureaus, YWCAs, mothers' clubs and aid centers, rape crisis and abuse centers, women's museums, ethnic organizations, organizations against sexual exploitation and violence, child and mother welfare societies, lesbian organizations, and research and study centers.

Audiovisual Reviews

ALADAR
Pribram/Wiener Productions, 840 Widener Road,, Elkins Park, PA 19117, 215/548-7699; ½" video, $350, ¾" video, $400.

In this video, a fascinating, creative, and spirited man named Aladar speaks his mind about his work, his life, and his personal struggle against AIDS. Until his death on November 1, 1988, Aladar was one of the survivors, part of a growing number of individuals who function with the disease for a long period of time. This video is testimony to his courageous survival, aided by numerous experimental drugs and the support of family and friends. As a tribute to that courage and strength, the video has an important message—in Aladar's words: "a war must be fought against the stigma of AIDS as well as the disease itself."

In *Aladar,* narrated by Aladar himself and his close friend, the artist Elaine de Kooning, the viewer is exposed to Aladar's remarkable spirit and will to live. The reality of his daily struggle with AIDS strikes home as we are shown Aladar in both his good *and* bad moments. We see a poignant depiction of the slow and steady advance of the disease accompanied by Aladar's painful up and downs—a perpetual roller coaster of health and disease. But, throughout, we also experience his strong will to live—a will enhanced by the hope that comes, most often, in the form of new experimental drugs that *might* buy a little more time—and with Aladar, we hope that each one will help him more than it will hurt him. A particularly touching segment depicts Aladar in the midst of an especially difficult bout with his illness. With the help of drugs, he "improves" dramatically and his world is immediately "rosier" and his/our hopes are once again sparked. Yet the questions linger, "Can he really fight it off?" and "For how long will he be able to do it?" And these questions are not easy to dismiss, for we are forced to recognize how fragile is this optimism and how ephemeral is our renewed hope for Aladar's ultimate survival.

Highlights of the film include a frank disagreement between Aladar and his sister about whether or not his mother should be told about his disease (Aladar wants to keep it from her as long as possible) and informative discussions about the pros and cons of experimental drugs which are designed to slow down the disease's progression. One portion of the film seems inappropriate and could be cut: a flat-toned medical expert provides "the facts about AIDS" and contributes nothing to the film. If the intent of this segment is to provide the viewing public with necessary AIDS information, this could be better done by coupling the showing of *Aladar* with one of the many available and good AIDS education films now on the market.

In technical terms, the film is professionally done, with excellent photography. The aesthetic component is strongly evident in the frequent backdrop of a blue-toned series of "Aladar portraits," painted by de Kooning, and in the small, artistic touches of Aladar's environment—the textures, colors and ambiance of Aladar as art purveyor and dealer. In this regard, the film comes across as soft and sensually-pleasing.

The film is appropriate for an older, more sophisticated audience, which could include late teens and college students, professionals and, among the lay public, those who are already familiar with HIV transmission and prevention. It is certainly *not* your ordinary factual AIDS education film nor is Aladar your average PWA (person with AIDS) who is dependent upon social service systems to afford the physical and financial ravages of the disease. Money appears to be no object to Aladar and, in this respect, he is much more fortunate than the majority of PWAs. *Aladar,* nonetheless, is highly recommended by the SIECUS Audiovisual Review Panel as a very special film about a very special man—Aladar. **LT, A, P, PR**

This review was written by Diane de Mauro, SIECUS director of program services.

SEXUAL ABUSE PREVENTION: A MIDDLE SCHOOL PRIMER.
Human Relations Media, Inc., 175 Tompkins Avenue, Pleasantville, NY 10570, 1987. Video (Part 1, 16 min., Part 2, 13 min.); Teacher's Guide. Price: $159.

This excellent video, in two parts, offers students ways to identify and respond to sexual abuse. Narration by a school psychologist and a teacher provide reassurance that sexual abuse can be prevented in some cases and halted in others, and that it is possible for victims of sexual abuse to deal with their experiences and feelings through therapy and go on to lead healthy and productive lives.

In Part 1, Listening to Your Feelings, a series of three scenarios in which sexual abuse occurs, conveys a strong message that sexual abuse is a frightening, negative experience which is not only wrong but illegal. Each scenario explores and validates the victims' emotions and reactions to abuse. The scenarios include abuse of two girls and one boy by a gymnastics coach, a director of community youth programs, and a neighbor.

In Part 2, Trouble at Home, a teacher who notices extreme behavior changes in one of her best students, confronts the girl and learns that she is being sexually abused by her father. The teacher helps the girl by revealing that she, too, was the victim of incest by her father, by telling her how she stopped the abuse, and by accompanying her to see the school guidance counselor. Despite the difficulty that one may have in revealing a family member as his/her abuser for fear of what may happen, it is essential to reveal the

abuser because everyone involved needs help in order to deal with and to correct the problem.

Strong, positive qualities of the video include the clear and thorough presentation and the refutation of the myths: that sexual abuse occurs most often with strangers; that it happens only to girls; that abuse is somehow the victim's fault; and that there are few incidents of abuse. The video encourages assertive attitudes, trusting one's feelings, and not being afraid to say "no" or to question someone just because they are an adult. It stresses that each individual has the right to decide when he or she will be touched, and by whom, and distinguishes between good and bad touches.

It is unfortunate that such a fine video perpetuates a number of racial and gender stereotypes which conflict with its overall positive attitude toward sexuality. The psychologist could assure the boy that his abuse by another male does not mean that he is homosexual without giving homosexuality negative connotations. The absence of a positive male role model is reflected by the fact that all the abusers in the video are male, while all those who offer support and guidance to the victims are women. While the parents of the white male and female victims provide support and understanding, the families of the two black female victims are not mentioned; and it is a white teacher who aids one black girl. As often happens, genitals are referred to as "private parts." The video also assumes that abuse is always by someone older and stronger, and it fails to deal with abuse by a peer or by someone younger.

In spite of these problems, this video is useful, because it shows young people what they can do if they are being abused, and it shows parents and educators how to respond if they suspect abuse. A thoughtful manual provides suggestions for teachers. **ET, P, PR**

This review was written by Lisa A. Bellin, an Oberlin College intern, supervised by Peggy Brick, Director, Center for Family Life Education, Hackensack, NJ.

The SIECUS Audiovisual Review Panel for these audiovisual films were: Lisa A. Bellin, Oberlin College intern, Center for Family Life Education, Hackensack, NJ, Peggy Brick, MEd, Director, Center for Family Life Education, Hackensack, NJ; Haydee Maldonado, BA, graduate student, New York University's Human Sexuality Program; Ellen Schneier, RN, graduate student, New York University's Human Sexuality Program; and SIECUS staff—David Boyd, former Administrative Assistant, Raquel Burgos, Membership Coordinator, Diane de Mauro, PhD, Director of Program Services, Janet Jamar, BS, Director of Publications, Fred Nesta, MS, former Librarian, and Jeanette Reyes, Membership Assistant.

MEDIA RESOURCES

PPFA/PPNYC FILM LISTING

Parent Education Program, Planned Parenthood of New York City, Inc., Room 416, 161-10 Jamaica Avenue, Jamaica, NY 11432, 718/526-5990.

The film library of Planned Parenthood of New York City, Inc. (PPNY) is now loaning films, videos, and cassette tapes. Any combination of two films, tapes, or cassettes may be borrowed for a fee of $10 per week. The number of weeks needed must be indicated at the time of request. Late charges are $5 per week. One must arrange to have the films, tapes or cassettes picked up and returned or must forward the cost of postage to them in advance of receiving the films, tapes or cassettes. Among the topics covered are abortion; healthy children; becoming an adult; birth control; changing roles of men and women; pelvic and breast examinations; sexuality with physical disability; parenting; sexually transmitted diseases; infertility; menstruation; decision-making, child abuse, sterilization, and male and female sexuality issues.

RESOURCE GUIDE: A LISTING OF AUDIOVISUALS (16mm films, ½" videotapes, audiocassettes, filmstrips, and educational games)

Center for Family Resources, 384 Clinton Street, Hempstead, NY 11550, 516/489-3716.

This resource guide (September 1988) provides a listing of audiovisual resources that are available on loan from the Center for Family Resources (CFR). It covers materials dealing with adolescent development; adolescent sexuality; caregiving and the elderly; child abuse prevention; communication; coping with stress; divorce/single/step parenting; parent education; the impact of the media; male-female sex roles; marriage and family; the changing context of sexuality education; prenatal care, sexuality and the disabled, sexually transmitted diseases; substance abuse; teen parenting; and work/family life. CFR staff will take reservations by phone or mail. They will need the name of the member, school, or agency, etc.; the contact person; the date of pick-up and the date of return. All pick-ups and returns are the responsibility of the borrower. Under some circumstances videotapes will be mailed at a charge of $5. Resources may be borrowed for one week, up to three resources at a time. The guide is free.

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Other Information Resources

ABORTION

INFORMATION FOR WOMEN UNDER 18: OBTAINING COURT CONSENT FOR AN ABORTION (*8-panel foldover pamphlet,* September 1987). Massachusetts law requires parental or judicial consent for anyone under 18 who is seeking an abortion. Planned Parenthood League of Massachusetts, through their counseling and referral program, provides free, confidential counseling and assistance to young women. Trained counselors discuss all pregnancy options with teens and explore the possibility of involving their parents in their decision. If they decide to have an abortion but are unable or do not choose to obtain their parents consent, counselors help teens obtain court consent. This pamphlet provides family planning and abortion providers, educators, youth workers, and teens with details about the parental consent law and how it is implemented. It also includes information on deciding what to do, out-of-state abortions, preparing for court, what happens in court, and paying for an abortion. *Planned Parenthood League of Massachusetts, Public Affairs & Information Department, 99 Bishop Allen Drive, Cambridge, MA 02139, (617) 492-0518. Price: $.10 each.*

AIDS

AIDS: ADMINISTRATION ISSUES (July 1987, 8 pp., *bibliography*) compiled by the staff of the American Hospital Association (AHA) Resource Center, recognized nationwide as a comprehensive information center for healthcare professionals, researchers, educators, librarians, policy analysts, and health care historians. Additional sources of information on this topic, they state, may be identified through the Health Planning and Administrative database and the *Hospital Literature Index* produced through the AHA Resource Center. Covers prevention and control; services, facilities, and costs; patient care; AIDS in the workplace; and legal and ethical issues. *AHA Resource Center, 840 North Lake Shore Drive, Chicago, IL 60611, 800/621-6712 x6263, in Illinois, 800/572-6850 x6263.*

Publications from **AIDS PROJECT LOS ANGELES: ISSUES** (quarterly newspaper) designed to inform the public about the current AIDS crisis, particularly in Los Angeles County, and to encourage people to take active, intelligent roles in responding to this crisis. **FOCUS ON AIDS: A MEDIA REPORT** (newsletter format) offers up-to-date information from the project on news, events, fundraising activities, training programs, conferences and workshops. **AIDS AND THE WORKPLACE** (1985, 5x7, 10-panel *foldover pamphlet*) discusses personal contact, the bathroom, food and drink, tools and utensils, and blood. **SIDA: SINDROME DE IMUNO DEFICIENCIA ADQUIRIDO** (8⅜ x 3½, *foldover pamphlet*) covers general facts about AIDS. *AIDS Project Los Angeles, 3670 Wilshire Blvd., Suite 300, Los Angeles, CA 90010, 213/380-2000.*

ALGUNOS DATOS QUE DEBE DE SABER ACERCA DEL SIDA/SOME THINGS YOU SHOULD KNOW ABOUT AIDS (1988, 11x4¼, *information card*) and **COMO UTILIZAR EL CONDON/HOW TO USE A CONDOM** (1988, 2½x3¾, *foldover pamphlet*) have been written to be used in education efforts aimed at the prevention of AIDS. "Statistics presently show that the Hispanic communities are disproportionately affected by this deadly epidemic and men and women need to learn about risky behaviors and the protection provided by condom usage." The pamphlets were translated by Victor Chevere, programs director of the Hispanic Center of Oklahoma City. *Education Department, Planned Parenthood of Central Oklahoma, 619 Northwest 23rd Street, Oklahoma City, OK 73103, 405/525-0344. First pamphlet prices: 0–99 copies/$.25 each; 100–199/$.18; 200–999/$.16; 1000+/$.15. Second pamphlet prices: single copy/$.35; 100–249/$.13; 250–499/$.11; 500–999/$.09; 1000+/$.07. Add 20%/orders to $100, 15%/$100–300, 10%/$300+ for p/h.*

Publications from the **SAN FRANCISCO AIDS FOUNDATION: AIDS EDUCATOR** (Fall 1988, 31 pp., 8½x11 *catalog*). Includes over 90 items: "The materials in this catalog have been developed by health educators and counselors who have been working in the field. Our goal is to provide easy access to a wide variety of effective AIDS education and training tools." **BETA: BULLETIN OF EXPERIMENTAL TREATMENT FOR AIDS** (1988, 8 pp., 8½x11 new *bimonthy bulletin,* distributed free in San Francisco), an educational resource for people considering experimental treatments. To protect confidentiality, it is mailed in a plain envelope. **RISKY BUSINESS** (1988, 20 pp., *comic book,* $1 each) includes two stories: "AIDS Virus" and "Risky Business." Intended for teenagers aged 13–17, it is illustrated with "multi-ethnic graphics" and provides information about AIDS using humor. Topics include IV drug use, cleaning IV needles, abstinence, condom use, antibody testing, the immune system, etc. Includes a glossary and a list of the questions most asked by teenagers. **EL DESPERTAR DE RAMON: UNA FOTONOVELA SOBRE EL SIDA (AIDS)/THE AWAKENING OF RAMON** (1988, tabloid-format *fotonovela,* $.30 each) produced by the Novela Health Foundation and People of Color Against AIDS Network with support from the Washington State AIDS Office. Provides basic facts about AIDS. **THE ADVENTURES OF BLEACHMAN: BLEACHMAN BRINGS HIS SECRET WEAPON TO EARTH TO FIGHT AIDS** (1988, 3⅜x8½, 10-panel *foldover pamphlet,* Spanish on alternate side). Uses comic book illustrations to explain that bleach kills the virus; and Bleachman, the superhero, provides specific instructions on how to clean needles. **TALKING WITH YOUR TEEN ABOUT AIDS** (1988, 3¾x8¾, *foldover pamphlet,* also available in Spanish). The message of this pamphlet: "...they don't think that AIDS could happen to them. They need to hear the truth. Talk with your teen about AIDS....Share the facts....Share your feelings....Listen!" **CONDOMS FOR COUPLES** (1988, 3⅜x8½, *foldover pamphlet).* Simple, precise information on how to use, put on, and talk to others about using condoms. **PREGNANCY AND AIDS** (1988, 3⅜x8½, *foldover pamphlet*). Offers information on how pregnant women might transmit HIV to their unborn children; statistics on women with AIDS; risk factors, deciding to take the HIV antibody test, getting help in making decisions in regard to AIDS, and protecting oneself and one's partner. **WHICH WOULD YOU CHOOSE?...** (1988, 2¾x2¼, *foldover wallet-sized pamphlet,* $.25 each). "Your money or your life?

Use condoms." Designed to contain a real condom. It also lists unsafe sexual practices. All available from: *San Francisco AIDS Foundation, Materials Distribution Department, 333 Valencia Street, 4th Floor, POB 6182, San Francisco, CA 94101-6182, 408/438-4080.*

WOMEN AND AIDS INFORMATION PACKETS have recently been sent to 500 campus and community-based women's centers throughout New York and New Jersey as part of the Women's Action Alliance's (WAA) efforts to increase awareness about how AIDS affects women and to support community-based groups in meeting the challenges posed by AIDS. These action-oriented kits are designed to encourage women's centers to provide AIDS prevention and support efforts vital to the women they serve. The kit includes **NEW YORK SERVICES**, a list of key AIDS organizations and service providers throughout New York; **NEW JERSEY SERVICES**, key AIDS organizations and service providers throughout New Jersey; and **EDUCATIONAL MATERIALS**, a selective list of materials targeted to women, minorities, and special populations—and a diversity of age groups. "Materials that stress a 'Just Say No' approach to prevention were not included in this listing, because we believe this approach is neither relevant nor useful to the vast majority of persons in need of AIDS prevention information." WAA states that these materials "are the most comprehensive up-to-date listing of services and prevention/education materials for women currently available. . . .we would encourage you to share these important resources with your colleagues—we only ask that the cover page crediting the Women's Action Alliance and the Women's Centers and AIDS Project be included when reproducing them." They will provide limited copies of these guides upon request. *Beverly Foster, Women's Action Alliance, Inc., 370 Lexington Avenue, New York, NY 10017, 212/532-8530.*

CHILD SEXUAL ABUSE

CHILD SEXUAL ABUSE (1985, 14 pp., 3⅜x8½ *booklet*). This booklet answers such questions as: Is sexual abuse of children a new phenomenon? Which children are affected? Are some more vulnerable than others? Who abuses children sexually? What forms does sexual abuse take? How can a child be led into sexual activities? How is sexual abuse detected? What kinds of psychological damage occurs? If I suspect sexual abuse, what should I do? What if my child has been sexually abused and needs medical attention? Can sexual abuse of children be prevented or reduced? What about child-care centers? Should parents feel uncomfortable about displaying affection toward their children? Recommends reading resources. *American Academy of Pediatrics, Department of Publications, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007. Prices: minimum order 100/members $15, nonmembers $20.*

CHILD SEXUAL ABUSE PREVENTION: AN EDUCATIONAL BROCHURE FOR ADULTS CONCERNED ABOUT CHILDREN WITH PHYSICAL HANDICAPS (1988, 3¾x8½, *foldover pamphlet*). Defines sexual abuse; tells how to report cases; mentions appropriate persons and organizations for referrals; provides facts and statistics; lists physical, behavioral and familial indicators; explains what parents can do; and suggests printed resources for parents and children on the topic. A videotape will also soon be available on the topic. *Planned Parenthood Association of Cincinnati, 2314 Auburn Avenue, Cincinnati, OH 45219, 513/721-8932. Prices: single copy free, bulk rates available on request.*

FAMILY PLANNING

DIEZ IDEAS RIDICULAS QUE HARÁN UN PADRE DE USTED/TEN RIDICULAS IDEAS THAT WILL MAKE A FATHER OUT OF YOU (1988, 3¾x8½, *foldover pamphlet*). A Spanish translation of this pamphlet has been produced due to requests from health organizations who have successfully used the English version (more than 400,000 copies have been used in public education programs across the United States). *Planned Parenthood of Central Oklahoma, 619 Northwest 23rd Street, Oklahoma City, OK 73103, 405/525-0344. Prices: 0–99 copies/$.25 each; 100–199/$.18; 200–999/$.16; 1000+/$.15. Add 20% for orders up to $100, 15%/$100–300, 10%/$300+ for p/h.*

FAMILY INVOLVEMENT IN FAMILY PLANNING—A RESOURCE GUIDE (1988, 70 pp., 8½x11, *resource guide*). "This guide is intended to enable Title X family planning programs to identify and utilize educational materials and methods that enhance positive parent-child interaction during the course of the child's learning about sexuality and related issues and the development of sound values and decision-making skills for dealing with those issues." It has been developed by James Bowman Associates, Inc. (JBA) through a contract with the Texas Educational Foundations, Inc. The guide is the result of a review of family involvement materials from around the nation. It includes 64 descriptions of materials and programs—recommended or strongly recommended by JBA—from approximately 200 selected individuals and organizations. The first part of the guide contains charts that list the titles of all the reviewed programs and materials by the topics they address, who might use them, and the kind of audiences with which those programs and materials should be effective. Further descriptions of the items are found in the second part of the guide. *James Bowman Associates, Inc., 2229 Lombard Street, San Francisco, CA 94123, 415/563-0909. Prices: 1–10/$12 each; 11–50/$10; 51+/$8.50.*

FAMILY LIFE MATTERS: A PUBLICATION OF THE NEW JERSEY NETWORK FOR FAMILY LIFE EDUCATION (3 issues a year, *newsletter*) provides information of interest to family life educators and an opportunity to network with colleagues. Lists grant opportunities, conferences, and materials of interest. *The New Jersey Network for Family Life Education, Rutgers University, Building 4087, Kilmer Campus, New Brunswick, NJ 08903, 201/932-7929. A year's membership is $10.*

SEXUALITY PERIODICALS FOR PROFESSIONALS

A SIECUS Annotated Bibliography

As with all other areas of specialization, there are numerous periodicals which address various issues in the field of human sexuality. These journals cover a broad range of topics which are relevant to the sexuality profession. The SIECUS library staff has compiled this bibliography to assist professionals in locating the publication that will meet their specific needs. All ordering information is current as of January, 1989.

One to four copies of this bibliography are available on receipt of $2.50 per copy and a stamped, self-addressed, business-sized envelope. In bulk, they are $2.00 each for 5-49 copies and $1.25 for 50 copies or more. Please add 15% to cover postage and handling.

This annotated listing of sexuality periodicals was prepared by Daniel M. Donohue, SIECUS' Librarian, and Mark O. Bigler, MSW, Graduate Assistant. For subscriptions to the periodicals listed, write directly to the publishers.

ARCHIVES OF SEXUAL BEHAVIOR: AN INTERDISCIPLINARY RESEARCH JOURNAL
International Academy of Sex Research

Richard Green, MD, JD, of the University of California at Los Angeles School of Medicine, edits this bimonthly journal of research studies which will enhance the understanding of human sexual behavior. Provides announcements of meetings and conferences. An index is available in the last issue of the volume.

Plenum Publishing, 233 Spring Street, New York, NY 10013. Annual subscription: $54.50 individual, $225 institutional.

AUSTRALIAN JOURNAL OF SEX, MARRIAGE, AND FAMILY
Family Life Movement of Australia

Alan Craddock is the editor of this quarterly journal which is designed to meet the research and information needs of professionals working in the areas of marriage, family, and sexuality. Provides book reviews and abstracts of articles from other journals.

Australian Journal of Sex, Marriage & Family, P.O. Box 143, Concord, N.S.W. 2137, Australia. Annual subscription: $30 (Australian dollars).

BEHAVIOR TODAY

Incorporating *Sexuality Today* and *Marriage and Divorce Today*, this weekly newsletter, edited by Ira Rosolosky, reports on all types of developments within the sexuality field.

ATCOM, 2315 Broadway, New York, NY 10024. Annual subscription: individual, $125 (one year), $230 (two years); institutional, $150 (one year), $275 (two years).

BRITISH JOURNAL OF SEXUAL MEDICINE
Medical Tribune Group, Ltd.

This monthly publication for physicians, edited by Dr. Alan J. Riley, provides medical information on research and treatment in the sexuality field.

The Medical Tribune Group, Tower House, Southhampton Street, London WC2E 7LS, England. Annual subscription outside Great Britain: £40 (approximately $60).

EMPHASIS SUBSCRIBER SERVICE
Planned Parenthood Federation of America

Subscribers annually receive: two issues of the periodical *Emphasis*, each with a program-oriented theme; three annotated bibliographies, in some instances coordinated topically with *Emphasis*; three reference sheets; one

white paper ("think pieces" on issues); and *Linkline*, a bimonthly newsletter of activities and publications. Subscribers are also entitled to two searches of LINK (Library and Information Network). Mike McGee is the editor.

Department of Education, Planned Parenthood Federation of America, 810 Seventh Avenue, New York NY 10019. Annual subscription: $48.

FAMILY LIFE EDUCATOR
Network Publications

Mary Nelson edits this quarterly publication of the National Family Life Education Network. It includes summaries of recent information and developments in family life education, annotations and reprint information from recently published journal articles, legislative updates, film and book reviews, and suggestions for classroom activites.

Network Publications, P.O. Box 1830, Santa Cruz, CA 95060-1830. Annual membership (including subscription): $30 individual, $40 institutional.

FAMILY PLANNING PERSPECTIVES
Alan Guttmacher Institute

This bimonthly periodical, edited by Denise Kafka, includes articles reporting on research in the areas of family planning; abortion; sex education; and adolescent sexuality, pregnancy, and parenthood. Book reviews, short news items and research articles are included. The Alan Guttmacher Institute also publishes *International Family Planning Perspective* and *Washington Memo*. The *Washington Memo* reports on legislative events, legal notes and commission reports, while the *International Family Planning Perspectives* has the same focus as *Family Planning Perspectives*, but has an international slant.

Alan Guttmacher Institute, 111 Fifth Avenue, New York, NY 10003. Annual subscription: Family Planning Perspectives, *$32 individual, $90 institutional, $132 library.* International Family Planning Perspectives, *$22 individual, $32 institutional.* Washington Memo, *$45 individual, $55 institutional. Ordered together: $76 individual, $100 institutional.*

JOURNAL OF HOMOSEXUALITY

John P. DeCecco, PhD, director of the Center for Research and Education in Sexuality (CERES) at San Francisco State University, edits this journal. It presents theoretical, empirical, and historical research on homsexuality; bisexuality; heterosexuality; sexual identity; and the sexual relations of both men and women. This journal is issued quarterly and is published in two volumes each year.

Haworth Press, 28 East 22 Street, New York, NY 10010-6194. Annual subscription (per volume): $32 individual, $90 insittutional, $140 library.

JOURNAL OF SEX AND MARITAL THERAPY

This quarterly journal emphasizes new therapeutic techniques, research on outcome, and special clinical problems, as well as the theoretical parameters of sexual functioning and marital relationships. The editors are Helen Singer Kaplan, MD, PhD, Clifford J. Sager, MD, and Raul C. Schiavi, MD.

Brunner/Mazel, 19 Union Square West, 8th Floor, New York, NY 10003. Annual subscription: $34 individual, $65 institutional.

JOURNAL OF SEX EDUCATION AND THERAPY
American Association of Sex Educators, Counselors, and Therapists

Edited by Gary F. Kelly, this quarterly journal includes research reports on sexual attitudes and behaviors, sex education and therapy. Provides resource reviews.

American Association of Sex Educators, Counselors, and Therapists, 11 Dupont Circle, NW, Suite 220, Washington, DC 20036. Individual annual membership (including subscription): $110 educators, $130 counselors, $150 therapists. Annual subscription for nonmembers: $30 individual, $50 institution.

JOURNAL OF SEX RESEARCH
Society for the Scientific Study of Sex

Paul Abramson, PhD, of the Department of Psychology at the University of California, Los Angeles, edits this quarterly publication which serves as a forum for the interdisciplinary exchange of knowledgee among professionals concerned with the scientific study of sexuality. Brief reports, clinical reports, and book reviews are included.

Society for the Scientific Study of Sex, P.O. Box 208, Mt. Vernon, IA 52314. Individual annual membership (including subscription): $80. Annual subscription for nonmembers: $45 individual, $70 institutional.

JOURNAL OF SOCIAL WORK AND HUMAN SEXUALITY

Published biannually, this periodical presents material of generic interest to social workers involved with the broad range of issues pertaining to human sexuality and family planning. The editor is David A. Shore, of Southern Illinois University.

Haworth Press, 12. W. 32nd Street, New York, NY 10001. Annual subscription: $30 individual, $75 institutional, $85 library.

MEDICAL ASPECTS OF HUMAN SEXUALITY

Edited by Charlotte N. Isler, this monthly journal covers the clinical and psychological components of human sexuality and of family life.

Hospital Publications, Inc., 500 Plaza Drive, Secaucus, NJ 07094. Annual subscription: $35 individual; $25 medical students.

SEX EDUCATION COALITION NEWS
Sex Education Coalition

This periodical's wide-ranging lead articles, book and audio-visual reviews, and other features make it of national interest.

Sex Education Coalition, 2001 O Street, NW, Washington, DC 20036. Individual annual membership (including subscription): $25.

SEX ROLES: A JOURNAL OF RESEARCH

Phyllis A. Katz, of the Institute for Research on Social Problems, Boulder, Colorado, edits this monthly journal which is concerned with the basic processes underlying gender role socialization and its consequences. Two volumes of 12 issues are published each year.

Plenum Publishing, 233 Spring Street, New York, NY 10013. Subscription rate per volume: $27.50 individual, $175.00 institutional.

SEXUAL AND MARITAL THERAPY

This international journal for those concerned with sexual and marital problems is the official publication of the Association of Sexual and Marital Therapists which is based in England. It features results of original research, subject reviews, accounts of therapeutic and counseling practice, case studies, book reviews, and abstracts of current literature. This publication is edited by Dr. P.T. Brown and Dr. A.J. Riley.

Carfax Publishing, P.O. Box 25, Abingdon, Oxfordshire OX14 3UE, England. Write for price information.

SEXUALITY AND DISABILITY

Arnold Melman, MD, of Beth Israel Hospital in New York City, edits this quarterly journal. It presents clinical and research developments in the area of sexuality as they relate to a wide range of physical and mental illnesses and disabling conditions.

Human Sciences Press, 233 Spring Street, New York, NY 10013. Annual subscription: $38 individual, $82 institutional.

SEX OVER FORTY

This practical newsletter, published monthly, is directed to the sexual concerns of adults. It is edited by Paul A. Fleming, MD, DHS, and is intended for the nonprofessional person.

PPA, Inc, P.O. Box 1600, Chapel Hill, NC 27515. Annual subscription: $72.

SIECCAN JOURNAL
Sex Information and Education Council of Canada

This quarterly journal, edited by Dr. Michael Barrett, presents articles, research notes, book reviews, and conference postings. The *SIECCAN Newsletter,* which features book and audiovisual reviews on human sexuality, is included with some of the issues of the *SIECCAN Journal.*

Dr. Michael Barrett, C/O Department of Zoology, University of Toronto, Toronto, Ontario T5S 1A1 Canada. Annual membership (including subscription): $30 (Canadian dollars) individual, $40 (Canadian dolars) institutional.

SIECUS REPORT
Sex Information and Education Council of the United States

This bimonthly publication, edited by Janet Jamar, features articles, research news, book and audiovisual reviews, specialized bibliographies, and resource and conference/workshop listings in the field of human sexuality.

Sex Information and Education Council of the U.S., New York University, 32 Washington Place, Room 52, New York, NY 10003. Annual membership (which includes subscription): $60 individual, $100 institutional, $60 library.

NEW JOURNALS

ANNALS OF SEX RESEARCH
Editor: Ron Langevin, PhD.
Frequency: Quarterly.

Juniper Press, P.O. Box 97, Islington Station B, Etobicoke, Ontario M9C 4X9 Canada. Annual subscription: $66 (Canadian dollars) individual, $100 (Canadian dollars) institution.

JOURNAL OF GAY & LESBIAN PSYCHOTHERAPY
Editor: David L. Scasta.
Frequency: Quarterly.

Haworth Press, 12 West 32nd Street, New York, NY 10001. Annual subscription: $24 individual, $30 institutional, $36 library.

JOURNAL OF PSYCHOLOGY AND HUMAN SEXUALITY
Editor: Eli Coleman, PhD
Frequency: Biannual

Haworth Press, 12 West 32nd Street, New York, NY 10001. Annual subscription: $20 individual, $28 institutional, $38 library.