THE AMERICAN BOARD OF SEXOLOGY

An Outline of Sexology

DISSERTATION
IN PARTIAL FULFILLMENT OF REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF EDUCATION

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TABLE OF CONTENTS

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Chapter 1

THE SEXOLOGICAL PERSPECTIVE

The sexological perspective develops out of awareness of the history of sexological discourse. At the beginning of this century, the pioneers of sexology mapped out a science that would explore every cultural, psychological and biological aspect of human sexual behavior from every conceivable viewpoint. Sexological study thrived, especially in Germany, until the National Socialist Party extinguished its life in 1933. Reborn in the United States, sexology again came under devastating attack in the McCarthy era. The Kinsey effort to create a significant record of data on sexual behavior was effectively halted, but the study of sexuality then expanded in different directions, awakening interest in thousands of scientists, clinical practitioners, academics, writers and media people. Today sexology is for, a third time, under political attack from those representing repressive/oppressive groups wishing to restrict the rights of individuals and cutting back the ways in which sexologists may function.

General references

Abramson, P.R. (1990). Sexual science: Emerging discipline or oxymoron? The Journal of Sex Research, 27(2). 147-165.

Bullough, V. L. & Bullough, B. (Eds.). (1994). *Human sexuality: An encyclopedia*. New York: Garland Publishing, Inc.

Bullough, V. L. (1994). *Science in the bedroom*. New York: Basic Books.

Davis, C. (1992). The state of sexual science: A look back to the 90's. Journal of Psychology and Human Sexuality, 5(3). 9-18.

Ellis, A. & Abarbanel, A. (Eds.). (1963). *Encyclopedia of sexual behavior*, (2nd ed.). New York: Hawthorne Books.

Francoeur, R., Perper, T. & Scherzer, N.A. (1991). *A descriptive dictionary and atlas of sexology*. Westport, CT: Greenwood Press.

Haeberle, E. J. (1983). The future of sexology-a radical view. In C. M. Davis, (ed.), Challenges in Sexual Science (pp. 141-160). Philadelphia: Society for the Scientific

Study of Sex.

Krivacska, J. & Money, J., (Eds.). (1987-1994). *The Handbook of forensic sexology: Biomedical and criminological perspectives.* New York: Prometheus Books.

Money, J. (1988). Commentary: Current status of sex research. Journal of Psychology and Human Sexuality, 1(1). 5-15.

Money, J. & Musaph, H. (1994). *Handbook of sexology, 6 Volumes with supplement.* Amsterdam: Elsevier.

Money, J., Musaph, H., Sitsen, J.M.A. & Perry, M.E. (Eds.). (1977, 1988, 1990). *Handbook of sexology,* Vols I-VII. New York: Elsevier Science Publishing.

Mosher, D. (1989). Advancing sexual science: Strategic analysis and planning. The Journal of Sex Research, 26(1). 1-4.

Reiss, I. L. (1982). Trouble in paradise: The current status of sexual science. The Journal of Sex Research, 18(2). 97-113.

Reiss, I. L. (1983). Paradise regained? A reply to Moser. The Journal of Sex Research, 19(2). 195-197.

Simon, W. (1989). Commentary on the status of sex research: The post modernization of sex. Journal of Psychology and Human Sexuality, 2(1). 9-37.

I. DEFINING SEXOLOGY

Sexology is the systematic study of human sexuality. Once stated, it is apparent that this definition oversimplifies. For one thing, in order to help understand human sexuality, sexologists find it necessary to study our sibling primates. For another, productive sexological research is sometimes unsystematic, and bears fruit. Furthermore, much of the valued work of sexologists is not study, but rather application in human service, artistic production, forensics, social reform and technology; all of this is sexology. Sexology is largely defined by its unique history of intellectual curiosity in the face of bitter repression, by its controversies, by its institutions and by the sum of the individual enterprises of sexologists: clinical, forensic, erotological, educational, research, organizational, political and so on.

A. Defining some key terms: sexology, sexual behavior and sexual drive.

1. Sexology is the rational and systematic study of humans and other animals as

sexual beings, i.e., of their biological properties as members of one or the other sex, of their sexual behavior in the broadest sense, of what they do sexually and how they feel about it.

2. Sexual behavior. This term is understood in three ways:

All actions and responses that make fertilization possible.

This oldest definition reflects the observation that each species of the higher animals is divided into two groups, male and female, and that they reproduce sexually. However, humans are not actually programmed for mating, and sexual behavior depends more on individual satisfaction and social goals than on fertilization.

Any behavior that involves a "sexual response." Motivation and purpose of sexual response remains obscure, so that it is advantageous to speak of sexual behavior without reference to its meaning. This usage is popular with sex researchers, who seek detailed descriptions of what people do before speculating on why they do it. This definition leads to study of all types of human sexual activity: self-stimulation, homosexual and heterosexual intercourse, animal contacts - without implying any hierarchical order.

All actions and responses related to pleasure seeking. This Freudian definition, and the concept of "sex" as underlying motive for every life-enhancing activity, has not proved as useful to scientists.

3. Sex drive.

The concept of sex drive has not proved useful in sexological discourse, although still in common use in the literature. It is more useful to differentiate between three factors that relate to the tendency to become sexually active:

Sexual capacity: what the individual can do

Sexual motivation: what the individual wants to do

Sexual performance: what the individual does.

Sexology Net Line
http://www.netaccess.on.ca/~sexorg/

The Society for Human Sexuality at the University of Washington, Seattle
http://weber.u.washington.edu/~sfpse/index.html

II. **HISTORY OF SEXOLOGY AND IMPORTANT CONTRIBUTORS**

Bullough, V. L. (1994). Science in the bedroom: A history of sex research. New York: Basic Books.

Foucault, M. (1978). The history of sexuality, (Vol. I). New York: Pantheon.

Haeberle, E. (1983). The sex atlas. New York: Continuum Publishing Company.

A. The pioneers of sexology

1. The concept of sexology, i.e., the study of sex as an academic discipline in its own right, was first proposed and outlined by the German dermatologist, Iwan Bloch.

Bloch, I. (1908). *The sexual life of our time*. New York: Rebman.

2.Precursors. Many others before him had made significant contributions to sexual knowledge - from Hippocrates, Plato, Aristotle and Soranus in antiquity to Avicenna, Averroes, Rhazes and other Islamic physicians in the Middle Ages to Leonardo (with his anatomical studies), Fallopio, deGraaf, Leuvenhoek and others in early modern times.

Tannahill, R. (1980). *Sex in history*. Briarcliff Manor, NY: Stein & Day.

3. Victorianism. Defining, preserving and strengthening a narrow concept of sexual propriety and "normality" became an increasing concern in the nineteenth century. This sexual Victorianism was accompanied by a concern with eliminating sexual abnormalities, perversions and deviations. In the 1880's, Krafft-Ebing, in his voluminous collection of case studies, introduced many new psychiatric terms such as "sadism" and "masochism."

D'Emilio, J. & Freedman, E.B. (1988). *Intimate matters: A history of sexuality in America.* New York: Harper & Row.

Krafft-Ebing, R. von (1965). *Psychopathia sexualis* (Adapted by F. J. Rebman). New York: Paperback Library.

Stekel, W. (1940). *Sexual Aberrations*. New York: Liveright Publishing Corp.

4. Understanding homosexuality. The Austrian-Hungarian writer, Kertbeny, who asserted that it was both normal and healthy, coined the term homosexuality in 1869. But the simplistic Victorian view - that sex was proper only between non-related adult males and females by means of coitus - counted homosexuality among the great number of deviations. Havelock Ellis and the German physician, Magnus Hirschfeld, challenged this view.

Ellis, H. (1936). *Studies in the psychology of sex*. New York: The Modern Library.

Hirschfeld, M. (1939). *Sexual pathology: A study of derangements of the sexual instinct*. New York: Emerson.

5. Magnus Hirschfeld edited the first Journal of Sexology in 1908, co- founded the first Society for Sexology in 1913, founded the first Institute for Sexology in 1919 and convened the first Conference on Sex Reform on a Sexological Basis in 1921 - all in Berlin.

6. Other pioneers. Early twentieth century Berlin sexologists were Albert Moll, Max Marcuse, who edited the Journal of Sexology, Ernst Grafenberg (who described the "G Spot"), Hans Lehfeldt, co-founder with Albert Ellis of the Society for the Scientific Study of Sex (in the United States) and Harry Benjamin, who pioneered treatment of transsexualism in New York.

Benjamin, H. (1966). *The transsexual phenomenon*. New York: Julian Press.

Moll, A. (1912). *The sexual life of the child*. New York: AMS Press.

7. Sigmund Freud, Austrian founder of psychoanalysis, constructed far-reaching theories of sexuality. Another Austrian psychoanalyst, Wilhelm Reich, pursued biological and biochemical studies, practiced bodywork, theorized about the correct orgasm, invented "orgone" and the orgone box and raised consciousness of sexual politics.

Freud, S. (1938). Three contributions to the theory of sex

(originally published 1910). In Brill, A. A. (Ed.), *The basic writings of Sigmund Freud*. New York: Modern Library.

Reich, W. (1965). *The sexual revolution: Toward a self-governing character structure*, 4th ed. New York: Farrar, Straus & Giroux.

8. In 1933 Germany was determined to exterminate the Jews and also to end any kind of sexual reform. The great majority of German sexologists were Jewish; they fled into exile. Their books were burned, their societies, journals, and the Hirschfeld Institute, closed down. The center of sexological activity then shifted to the United States.

Haeberle, E. J. (1983). *The sex atlas*. (Revised and expanded.) New York: Continuum Publishing.

B. Milestones in sexology's coming of age in America

Brecher, E. M. (1969). *The sex researchers.* Boston: Little, Brown.

Robinson, P. (1976). *The modernization of sex*. New York: Harper & Row.

1. Theodoor H. van de Velde, a Dutch gynecologist wrote a marriage manual in 1926 that quickly became a best-seller in the United States. It glorified marital sexuality and the simultaneous orgasm. Van de Velde's conceptualization of the sex response as dependent on skills (the husband's) went unchallenged until the publication of Masters and Johnson's *Human Sexual Inadequac*y in 1970.

van de Velde, T.H. (1965), *Ideal marriage*, (rev. ed.). New York: Random House.

2. Robert L. Dickinson, a physician-artist, observed and produced countless drawings of male and female sexual anatomy and physiology, establishing averages and range of variation.

Dickinson, R. L. (1949). *Human sexual anatomy: A topographical hand atlas*, (2nd ed.). Baltimore: Williams & Wilkins.

3. Alfred C. Kinsey established base-line knowledge of orgasm-seeking behavior in the United States - who does what, when, and with whom.

Kinsey, A.C., Pomeroy, W.B. & Martin, C.E. (1948). *Sexual behavior in the human male*. Philadelphia: Saunders.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E. & Gebhard, P.H. (1953). *Sexual behavior in the human female*. Philadelphia: W.B. Saunders.

Pomeroy, W. B. (1972). *Dr. Kinsey and the Institute for Sex Research.* New York: Harper & Row.

The Kinsey Institute
http:/www.indiana.edu/~kinsey/

4. Albert Ellis proposed a rational philosophy of sexuality as basis for individuals and society's sexual decisions, and a rational-emotive approach to solution of sexual and other problems of living. As other psychotherapists adopted Ellis' RET and created individual variations, it became known as cognitive-behavior therapy, the basic sex therapy intervention.

Ellis, A. (1965). *Sex without guilt*. (Rev. ed.). New York: Lyle Stuart.

Albert Ellis Institute
http://www.irebt.org/

5. William H. Masters & Virginia E. Johnson. First systematic observational study of the human sexual response in the laboratory. Brought new understanding of the physiology of sex. The appearance of sex therapy as a profession was a consequence of the published report on the Masters & Johnson sex therapy package.

Masters, W. & Johnson, V. (1966). *Human sexual response*. Boston: Little, Brown.

6. John Money pioneered the study of gender role and dysphoria, gender identity. Most prolific sex researcher, sexological writer and creator of neologisms of last two decades.

Money, J. & Ehrhardt, A. (1972). *Man and woman, boy and girl*. Baltimore: Johns Hopkins University Press.

John Money
http://www.gai.com/text/rept17.htm

7. Helen Singer Kaplan introduced new conceptual models for the human sexual response, brought sexual desire problems to the fore.

Kaplan, H.S. (1974). *The new sex therapy*. New York: Brunner/Mazel.

8. Ted McIlvenna & Laird Sutton, two Methodist ministers who chose sexuality as their ministry, invented the Sexual Attitude Restructuring (SAR), the sexual pattern film, and the doctoral program in human sexuality.

McIlvenna, R.T. & Sutton, L. (1977). *Meditations on the gift of sexuality*. San Francisco: Specific Press.

History and Concept of Sexology
http://www.indiana.edu/~kinsey/hstsexw.html

Sexology - A Brief History
http://www.netaccess.on.ca/~sexorg/erwinhis.htm

III. **CURRENT CONTROVERSIAL ISSUES**

A. Sexual rights. Sexologists drew up a Bill of Sexual Rights in the eighties. Today its principles are under attack from all sides.

1. The freedom of any sexual thought, fantasy, or desire.

2. The right to sexual entertainment, freely available in the marketplace, including sexually explicit materials dealing with the full range of sexual behavior.

3. The right not to be exposed to sexual material or behavior.

4. The right to sexual self-determination.

5. The right to seek out and engage in consensual sexual activity.

6. The right to engage in sexual acts or activities of any kind whatsoever, providing they do not involve nonconsensual acts, violence, constraint, coercion or fraud.

7.The right to be free of persecution, condemnation, discrimination or societal intervention in private sexual behavior.

8. The recognition by society that every person, partnered or unpartnered, has the right to the pursuit of a satisfying consensual sociosexual life free from political, legal or religious interference and that there need to be mechanisms in society where the opportunities of sociosexual activities are available to the following: disabled persons; chronically ill persons; those incarcerated in prisons, hospitals or institutions; those disadvantaged because of age, lack of physical attractiveness or lack of social skills; the poor and the lonely.

9. The basic right of all persons who are sexually dysfunctional to have available nonjudgmental sexual health care.

10. The right to control conception.

Barnett, W. (1973). *Sexual freedom and the constitution*. Albuquerque: University of New Mexico Press.

Haeberle, E. J. (1983). Human rights and sexual rights: The legacy of Rene Guyon. Medicine and Law, April.

Nobile, P. & Nadler, E. (1986). A Magna Carta for censors. Forum, 15(12). 44-55.

B. Conservative reaction. Under attack are:

Garrow, D. J. (1994). *Liberty and sexuality.* New York: MacMillan.

1. Sex education, in schools and books. Anti-sexual activists bring pressure on libraries, forcing exclusion of fiction that portrays sexual realities, and limiting holdings of sex information literature.

2. The individual's right to control conception and reproduction. The low-income woman's right to abortion counsel is threatened.

3. Pictorial representations of the human body and of erotic experience.

Attorney General's Commission on Pornography. (1986). *Final report*. Washington, DC: U.S. Dept. of Justice.

Dworkin, A. (1981). *Pornography: Men possessing women*. New York: Putnam.

C. Feminist critiques of sexology

Irvine, J.M. (1990). Disorders of desire: Sex and gender in modern American sexology. Philadelphia: Temple University Press.

Tiefer, L. (1988). A feminist perspective on sexology and sexuality. In M.M. Gergen (Ed.), Feminist thought and the structure of knowledge. New York: New York University Press. 16-26.

D. Re-medicalization of sexual dysfunction and other sexual problems in the eighties, development of high-tech interventions.

Schover, L. R. (1989). He-men & semen: The urological view of manhood. The Journal of Sex Research, 26(3) 400-401. (Review of Tanagho, Lue, & McClure, Eds.). Contemporary management of impotence and infertility.

E. HIV/AIDS controversies. Using the same epidemiological data, two contrary conclusions are drawn:

1. The entire population is at imminent risk for HIV infection (and because of this, funding for research should be escalated).

Masters, W.H., Johnson, V.E., & Kolodny, R.C. (1988). *Crisis: Heterosexual behavior in the age of AIDS*. New York: Grove Press.

2. Only the underprivileged, under-educated minorities are at risk, the epidemic has peaked, and "ordinary" heterosexuals are not at significant risk if they stay home.

Fumento, M. (1989). The myth of heterosexual AIDS: How a tragedy has been distorted by the media and partisan politics. New York: Basic Books.

F. The new addictionology and coaddictionism

1. The discovery of the sex addict, in 1983, followed shortly by the creation of a vast population of co-addicts, has opened economic opportunities for the helping professional.

Carnes, P.J. (1983). *Out of the shadows: Understanding sexual addiction*. Minneapolis: CompCare Publishers.

2. An opposing view of addictionology sees it as exploitative and iatrogenic, replacing socially scripted shame with palliative psychobabble and religiosity.

G. The rediscovery of child sexual abuse, and wife and acquaintance rape.

Sexology Net Line
http://www.netaccess.on.ca/~sexorg/answer.htm

VII. **SPECIAL LIBRARIES OF HUMAN SEXUALITY**

Directory of Special Libraries and Information Centers (Gale Research)
(Available in libraries with heading under "sex").

Kinsey Library, Kinsey Institute for Research in Sex, Gender and Reproduction, Bloomington, Indiana.

Libraries of The Institute for Advanced Study of Human Sexuality, San Francisco.

Mary S. Calderone Library, SIECUS, New York
New York: SIECUS
Phoenix, AZ: Oryx Press

Katharine Dexter McCormick Library of Planned Parenthood Federation of America, New York.

VIII. **PROFESSIONAL ORGANIZATIONS**

The American Academy of Clinical Sexologists, **AACS,** 1929 18th Street N.W., Suite 1166, Washington, D.C. 20009. (202) 462-2122.

American Association of Sex Educators, Counselors and Therapists, **AASECT**, Chicago, Illinois.

AASECT Home Page
http://www.aasect.org/

The American Academy of Clinical Sexologists, the fellowship organization affiliated with The American Board of Sexology, publishes:

CliniScope. Clinical monographs of interest to Fellows and Clinical Sexologists of The American Academy of Clinical Sexologists of recognized methods and procedures for inclusion in their practices.

How to get more information about certification. The American Board of Sexology requirements for certification are previously outlined. Those who meet the requirements and wish to become certified in any of four categories mentioned may write or call the Executive Director for an application form, or make inquiries if there are questions still unanswered about the process.

The American Board of Sexology, **ABS**, 1929 18th Street N.W., Suite 1166, Washington DC 20009. (202) 462-2122.

American Board of Sexology Home Page

http://aSexTherapy.com

Other Publications by The American Board of Sexology:

The Registry of Diplomates. This is a listing of all Diplomates of the Board who are currently certified. It is published annually in the Fall. It lists certified clinical sexologists, sex educators and sex researchers by state and provides information appropriate for selecting professionals such as name, address, phone, degree, schools attended, specialties and other useful information. Journalists and broadcast media producers will also find the Registry useful in selecting experts for appearances or interviews.

The DIPLOMATE. This is a newsletter of interest to Diplomates and consists of news for and about those certified by The American Board of Sexology. It is published quarterly.

International Academy of Sex Researchers, IASR, Toronto, ONT.

Sex Information and Education Council of the United States, SIECUS, New York.

SIECUS
http://www.siecus.org/

Society for the Scientific Study of Sexuality, **SSSS,** Mt. Vernon, IA.

SSSS, The Society for the Scientific Study of Sexuality
http://www.ssc.wise.edu/ssss/

Society for Sex Therapy and Research, **SSTAR,** St. Louis, MO.

World Association for Sexology (Spanish & English)
http://nti.uji.es/guest/congres_sexologia/WAS/WAS.html

IX. **EXPERIENTIAL PROCESS.** In order to relate appropriately-intelligently, non-judgmentally, and non-exploitatively to any client, student, assistant, co-worker, to the media or to the public, it is necessary that clinical sexologists have considerable contact with a broad diversity of sexual patterns and orientations and have observed the vast range of cultural reflections of sexuality. It is imperative that clinical sexologists have worked through their own sexual development to make possible a rich sexual life, whether partnered or self-sufficient. This is necessary in order to understand the sexual development process of individuals with whom

they have a professional relationship. This chapter outlines an experiential aspect of sexuality education that is essential to the personal and professional development of the clinical sexologist.

A. The SAR Process (8-day SAR) or equivalent experience. The Sexual Attitude Restructuring program, as originated, developed and offered annually by the National Sex Forum, is an opportunity to meet and learn about the lifestyles and sexuality of a broad sample of the population, including the sexually unusual, the disabled and the terminally ill, the celibate and the enthusiast, many varieties of sex professionals, sex workers and laypersons.

Ayres, T., Lyon, P., McIlvenna, T., Myers, F., Rila, M., Rubenstein, M., Smith, C. & Sutton, L. (1977). *SAR guide: For a better sex life*, 2nd ed., rev'd. San Francisco, CA: National Sex Forum.

1. Mini-SARs (12-hour condensations called Sexual Attitude Reassessments) are offered around the country, particularly preceding national conferences of sex profession societies. Some individuals may find repeated experience of a variety of mini-SARS to be a satisfactory substitute for the 8-day SAR.

2. The SAR uses sexually explicit audiovisual media for implosive desensitization to unfamiliar, normally covert, sexual behaviors. Lectures bring information, and many small group discussions make it possible for participants to talk about their reactions to the information and imagery. Strong feelings normally emerge, since most people - even experienced clinical sexologists - bring to the SAR life-long anxieties about one or another sexual orientation, life-style, bizarre or exploitative sexual proclivity.

3. The sex-affirmative SAR philosophy is seen by some clinical sexologists as oppressive, in that it conveys the message that people "should all be having a richer sex life and saying 'YES' to sex" in spite of the unpleasantness of sexual realities. The SAR is an unusual opportunity for becoming more aware of one's unexamined beliefs (brought to the surface by explicit media), and for clarifying one's values.

B. Sexual Health Attitude Restructuring Program**.** (SHARP) or equivalent experience. The SHARP is given each summer at the National Sex Forum in San Francisco. It is an opportunity for intensive education about HIV/AIDS, the other STDs and drug-use practices that put people at risk for contracting STDs.

1. SHARP is an 8-day (60 contact hours) practicum that gives direct practical experience using sexological techniques, teaching strategies and explicit materials for learning about, teaching and counseling about Safer Sex and other risk-reduction concepts.

   a) SHARP provides information about divergent sexual lifestyles and special sexual problems that AIDS educators encounter daily.

   b) It helps participants develop an effective sexual comfort level in relation to HIV, persons at risk and people with AIDS.

2. Clinical sexologists may find that the Health Departments in their cities offer courses and workshops, which can bring them closer to the populations that are most at risk for HIV/AIDS and other STDs. New York City has its AIDS Training Institute for service providers whose work demands that they be up-to-date and culturally sensitive about HIV/AIDS and its effects on the people with whom they work. Such community training institutes provide another experiential educational opportunity for the sexologist.

C. Sexological Body Therapy.

1. Direct bodywork (mainly massage) experience with all sorts of people, as basic training, helps the clinical sexologist to see human physical contact as an essential part of living for almost every human being. Intensive courses or workshops are strongly recommended, since some sexologists arrive at their sexuality profession work from other academic or medical disciplines, having had little previous experience with the bodies and sexual responses of other human beings. Learning massage is a way of overcoming anxieties about human contact and becoming capable of satisfying one's human needs for touch.

2. Caution: Strong recommendation of massage workshops for sexologists is not endorsement of any type of bodywork with clients. The sexologist may want to refer clients for massage or to a surrogate for body-contact experience, but body contact within the professional relationship appears to be counter-therapeutic. Clients may seek comforting hugs or hand-holding, but ultimately such gestures of warmth serve neither the client nor the clinical sexologist.

Heartwood Institute. Catalog: *Your guide to intensive programs*. Garberville, CA: Heartwood Institute.

D. Review and personal use of sexual material. A wealth of sexual materials exists in our environment. This material affects clients in many ways, and so it behooves clinical sexologists to acquire familiarity with these materials and become comfortable with them.

1. Sex education films and video. Since they are so widely distributed for their educational value, they surely belong in the sexologist's experience. What these educational aids provide is a wide range of human sexual behaviors and lifestyles presented from a positive value-oriented point of view.

Apfelbaum, B. (1984). Professional sex films versus sexual reality. In R.T. Segraves and E.J. Haeberle, *Emerging dimensions of sexology*.

Multi-Focus catalog. (1995). San Francisco: Multi-Focus.

Sex education, research & therapy. *1995 film & video catalog*. Huntington Station, NY: Focus International.

2. Erotic arts: film, theater, visual arts and literature. Michael Perkins does reviews of books with

erotic content, weekly in SCREW.

3. Mass market erotic films and video. After a decade in the doldrums, there is a renaissance of porn film and video.

4. Mass market erotic magazines and fiction. Besides those with mass circulations, like Playboy and Penthouse, there seem to be hundreds of special interest sexually explicit magazines, which the sexologist needs to explore - at least in order to be able to encompass in imagination the vast range of special interest fantasies of clients.

5. Sex toys and contraceptive devices. It is important for sexologists to be knowledgeable, comfortable and familiar with the vast array of sex toys and contraceptive devices available to consumers.

Blank, J. (1976). *Good vibrations*. The complete guide to vibrators. Burlingame, CA: Down There Press.

X. **CULTURAL REFLECTIONS OF SEXUALITY INTRODUCTION**.

The individual's sexual expression is organized, controlled and limited by each society. At the same time, society's institutions and artifacts take form from the individual's desires for sexual expression. In order to understand the varieties of sex-related experience, the sexologist needs to have wide familiarity with the concrete and the institutional forms that reflect human sexual interests.

General references

Reiss, I. (1986). *Journey into sexuality: An exploratory Voyage.* Englewood Cliffs, NJ: Prentice Hall.

Tannahill, R. (1981). *Sex in history*. New York: Stein and Day.

Webb, P. (1983). *The erotic arts*, rev'd ed. New York: Farrar, Straus, and Giroux.

Young, W. (1964). *Eros denied*. New York: Grove Press.

A. EROTOLOGY has been defined as the practical study of lovemaking or *ars amatoria*, including the study of all cultural expressions of sexuality.

1. Sexual imagery in fine art (erotic art).

a) Erotic art may or may not be arousing, depending on the mind-set of the viewer. Erotic art that has been created out of a desire to observe and record human behavior or appearance has great value for the sexologist and for society. It may provide the best records of sexual life today or in another era or another culture.

b) The body of erotic representations that is extant represents a tiny proportion of the world's erotic art production, much of which has been destroyed. Private collectors and art dealers largely hide in museums or what remains. The erotic art remaining in artists' studios after their death is often destroyed by their heirs.

Kronhausen, P. & Kronhausen, E. (1978). *The complete book of erotic art,* Vols. 1 & 2. New York: Bell Publishing.

Paglia, C. (1990). Sexual personae: Art and decadence from Nefertiti to Emily Dickinson. New York: Random House Vintage.

Steinberg, D. (Ed.). (1992). The erotic impulse: Honoring the sexual self. Los Angeles: Tarcher.

2. Sexuality in literature.

a) Contemporary mainstream novels realistically reflect sexual life in our world.

Joyce, J. (1934). *Ulysses.* New York: Random House.

Roth, P. (1967). *Portnoy's complaint*. New York: Random House.

b) Genre fiction (historical novels and romance fiction) mainly mean to entertain and arouse the reader. They reflect sexual conventions of publishing.

Anonymous. (1986). *My Secret Life*. (Abridged but unexpurgated). New York: Grove Press

Kingdon, F. (1967). Literature and sex. In A. Ellis & A. Abarbanel, (Eds.). *The encyclopedia of sexual behavior*, (rev'd 2nd ed.). New York: Hawthorn Books.

Legman, G. (1964). *The horn book*. New Hyde Park, New York: University Books.

Loth, D. (1961). *The erotic in literature*. New York: Julian Messner.

Miller, H. (1961). *The tropic of cancer.* New York: Grove Press.

3. Marriage manuals, sexual enhancement guides

a) Heterosexual guides. Sex enhancement manuals for marital or otherwise coupled people promise increasing intimacy, but there is no empirical evidence to back the promise - and it is possible that the recent crop brings as much pressure on the individuals and their relationships as did van de Velde's classic and Freud's fantasies of mature sexuality.

Britton, B. (1982). The love muscle: Every woman's guide to intensifying sexual pleasure. New York: New American Library.

Comfort, A. (1972). The joy of sex. New York: Simon & Schuster.

Ellis, A. (1960). The art and science of love. New York: Bantam Books.

Hartman, W. & Fithian, M. (1984). Any man can: The multiple orgasmic technique for every loving man. New York: St. Martin's Press.

O'Connor, D. (1989). How to put the love back into make love. New York: Doubleday.

O'Connor, L. R. (1969). The photographic manual of sexual intercourse. New York: Pent-R Books.

van de Velde, T. H. (1926). Ideal marriage. Revised (1965). New York: Random House.

Vatsyayana. (1964). The Kama Sutra. NY: Dutton. [Classic Hindu treatise on sex and social conduct.]

b) Homosexual guides

Isay, R.A. (1990). *Being homosexual.* New York: Avon.

Loulan, J. (1984). *Lesbian sex.* San Francisco: Spinsters.

Marcus, E. (1988). *The male couple's guide to living together*. New York: Harper & Row.

Silverstein, C. & Picano, F. (1992). *The new joy of gay sex*. New York: Harper Collins.

Sisley, E. & Harris, B. (1977). *The joy of lesbian sex*. New York: Simon & Schuster.

c) Autoerotic guides

Dodson, B. (1987). *Sex for one: The joy of masturbation*. New York: Harmony.

McIlvenna, T. & Sutton, L. (Photog.). (1973). *When you don't make it: The YES book of sex*. San Francisco: Multi-Media Resource Center.

Richter, H. (1982). *Joys of masturbation*. Palm Springs, CA: Merchandise for Mailers.

4. Pornography, obscenity and erotica.

Cornog, M. (1991). *Libraries, erotica and pornography.* Phoenix, AZ: Oryx Press.

Donnerstein, E. (1987). *The question of pornography: Research findings and policy implications.* New York: The Free Press. (Contains bibliographies re: libraries, erotica and censorship).

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McCuen, G. E. (1985). *Pornography and sexual violence*. Hudson, WI: Gary E. McCuen Publications.

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President's Commission on Obscenity and Pornography. (1970). Technical Report, (Vol. 5). Washington, DC: US Government Printing Office.

Wedeck, H.E. (1962). *Dictionary of erotic literature*. New York: Citadel Press.

5. Sex information/entertainment periodicals and enterprises.

C.J. Scheiner Books, 275 Linden Boulevard - B2, Brooklyn, NY 11226. (Antique and contemporary erotica).

EIDOS: Sexual freedom & erotic entertainment for women, men & couples. Boston, MA: Eidos.

Gellatly, P. (Ed.). *Sex magazines in the library collection.* New York: Haworth Press.

Ivan Stromgart Books, P.O. Box 1232 GMF, Boston, MA, 02205.

Libido: The Journal of Sex and Sensibility. Chicago, IL: Libido, Inc., 5318 North Paulina Street, 60640, (312) 275-0842.

Penthouse Forum, NY: Forum International.

Rutledge, L.W. (1987). *The gay book of lists*. Boston: Alyson Publications.

SCREW: The world's greatest newspaper. New York: Milky Way Productions.

The Sexuality Library, 1210 Valencia Street, San Francisco, CA 94110. (Catalog listings of books, magazines and videos related to sexuality and erotica)

Spectator Magazine. Emeryville, CA: Bold Type, Inc., 5835 Doyle Street, Suite 103, 94608, (510) 849-1615.

6. Sex in the popular media

a) Newspapers and magazines. The daily tabloids report on sexual violence. Women's mass magazines advise about sex and love, quoting sexual enhancement sexperts and researchers.

b) Film and video. In the nineties the amateur sex videos were capturing the market. There was also a return to the production of excellent quality sexually explicit film and video made by professionals, after a decade of dross, and beautiful, exciting porn produced by and for women.

Holliday, J. (1986). Only the best: Jim Holliday's adult video almanac & trivia treasure. Van Nuys, CA: Cal Vista.

Rimmer, R. H. (1986). The x-rated videotape guide, (Rev. and updated). New York: Harmony Books. [Continuously updated.]

Royalle, C. Femme Distribution, 588 Broadway, Suite 1110, New York, NY 10012. (Videos)

c) Television.

7. Sex in advertising and industry.

Fawver-Pickett, P. (1991). *Sexually explicit advertisements in women's magazines: Characters of erotic content*. Ph.D. dissertation, Institute for Advanced Study of Human Sexuality, San Francisco, CA.

Money, J. (1985). *The destroying angel: sex, fitness and food in the legacy of degeneracy theory, Graham crackers, Kellogg's Corn Flakes and American health history*. Buffalo, NY: Prometheus.

8. Sex, drugs and rock 'n' roll.

Groover, M. "King" Jr. (Nov./Dec. 1989) Hot Sounds: Prince of Porn. Penthouse Hot Talk, 2(3). 56-58.

XI. **RELIGION AND SEXUALITY**

Brusich, J. (1990). Religious influence and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders. 160-178.

Bullough, V. L. & Brundage, J. (1982). *Sexual practices and the medieval church.* Buffalo, NY: Prometheus Press.

Bullough, V.L. & Bullough, B. (1977). *Sin, sickness and sanity: A history of sexual attitudes.* New York: New American Library.

Goldberg, B.Z. (1958). *The sacred fire: The story of sex in religion*. New York: University Books.

Lawrence, R. (1989). *The poisoning of eros: Sexual values in conflict.* New York and Roanoke, VA: Augustine More Press.

Parrinder, G. (1980). *Sex in the world's religions*. New York: Oxford University Press.

A. Judaism

Borowitz, E. B. (1969). *Choosing a sex ethic*. New York: Schoken Books.

Edwardes, A. (1967). Erotica Judaica: *A sexual history of the Jews*. New York: Julian Press.

Gittelson, R. (1980). *Love, sex, and marriage: A Jewish view*. New York: Union of American Hebrew Congregations.

Gordis, R. (1978). *Love and sex: A modern Jewish perspective*. New York: Farrar, Strauss & Giroux.

Westheimer, R. & Mark, J. (1996). *Heavenly sex.* New York: Continuum Books.

B. Christianity

Boswell, J. (1980). *Christianity, social tolerance, and homosexuality*. Chicago, IL: University of Chicago Press.

Larue, G. (1983). *Sex and the Bible*. Buffalo, NY: Prometheus Books.

Nelson, J. & Longfellow, S. (Eds.) (1994). *Sexuality and the sacred: Sources for Theological reflection.* Louisville, KY: Westminster John Knox Press.

Pagels, E. (1988). *Adam, Eve, and the serpent*. New York: Vintage Books.

Russell, B. (1957). *Why I am not a Christian*. New York: Simon & Schuster.

Scanzoni, L. & Mollenkott, V. R. (1978). *Is the homosexual my neighbor? Another Christian view*. New York: Harper & Row.

1. Protestantism

American Lutheran Church (1980). *Human sexuality and sexual behavior*. Minneapolis: Office of Church Society.

Kelsey, M. & Kelsey, B. (1986). *Sacrament of sexuality: The spirituality and psychology of sex*. Warwick, NY: Amity House.

Spong, J.S. (1988). *Living in sin? A bishop rethinks human sexuality*. San Francisco: Harper & Row.

The Voice of Integrity. Publication of Integrity, Inc., Washington, DC.

2. Roman Catholicism

Archdiocese of Baltimore Gay/Lesbian Outreach (1986). *Homosexuality; a positive Catholic perspective*. Baltimore, MD: Roman Catholic Archdiocese.

Durkin, M.G. (1983). *Feast of love: Pope John Paul II on human intimacy*. Chicago: Loyola University Press.

Kosnik, A. et al. (1977). *Human sexuality: New directions in American Catholic thought*. Ramsey, NJ: Paulist Press. [Liberal views on sexuality.]

McNeill, J.J. (1985). *The church and the homosexual*. New York.

C. Other religions

Edwardes, A. (1962). The jewel in the lotus: A historical survey of the sexual culture of the East. New York: Julian Press.

1. Islam

Roberts, D. S. (1981). *Islam: A concise introduction*. New York: Harper & Row.

Saadawi, N. El. (1980). *The hidden face of Eve: Women in the Arab world*. Boston: Beacon Press.

2. Hinduism

Belfrage, S. (1981). *Flowers of emptiness: Reflections on an ashram*. New York: Dial Press.

3. Buddhism

Yuichi, K. (1982). Women in Buddhism. Eastern Buddhist, 15. 53-70.

4. Tao. The concepts of Tao are alive among non-Asians in the San Francisco Bay Area, but modern Chinese sexual attitudes tend to be quite conservative.

Chang, J. (1977). The tao of love and sex: The ancient Chinese way to ecstasy. New York: Dutton.

University of Washington Library, Religious Stances on Sexuality

http://weber.u.washington.edu/~sfpse/ftpsite.html#religion

XII. **SEXUALITY AND THE LAW**

Fogel, M.E. & Fogel, C.I. (1990). Sex and the law. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders.

Friedman, S. E. (1990). *Sex law: A legal source-book on critical sexual issues for the non-lawyer.* Jefferson, NC: McFarland.

Green, R. (1992). *Sexual science and the law.* Cambridge: Harvard University Press.

MacNamara, D.I.J. & Sagarin, E. (1977). *Sex, crime and the law*. New York: Free Press, MacMillan.

A. History of sex laws.

Haeberle, E.J. (1983). "Natural law" and the laws of nature, Legal-illegal, Sex and the law. In E.J. Haeberle, *The sex atlas*, rev'd and expanded ed., New York: Continuum. 339-366.

B. Social control of sexual behaviors affected by:

1. The President of the United States and appointees
2. Legislators and lobbies
3. The courts
4. The police
5. Postal service, customs, immigration service, intelligence, the military services.

C. First Amendment cases

Green, J. (1990). *The encyclopedia of censorship.* New York: Facts on File.

Hurwitz, L. (1985). *Historical dictionary of censorship in the U.S.* Westport, CT: Greenwood.

D. Domestic law (custody problems of gay and lesbian parents)

E. Criminal, sexual assault cases

F. Capital crimes involving sexual contacts

G. The sexologist as expert witness; courtroom mores

H. Sexual harassment

1. At school.

Dziech, B. W. & Weiner, L. (1984). *The lecherous professor: Harassment on campus*. Boston: Beacon Press.

2. At work.

MacKinnon, C. (1979). *Sex harassment of working women*. New Haven, CT: Yale University Press.

University of Washington Library, General Activism
http://weber.u.washington.edu/~sfpse/ftpsite.html#activism

XIII. **ETHICAL PERSPECTIVES: SEXOSOPHY AND SEX REFORM.**

Baker, R. & Elliston, F. (Eds.). (1984). *Philosophy and sex,* rev. ed. Buffalo, NY: Prometheus Books.

Fletcher, J. (1966). Situation ethics: The new morality; *Moral responsibility: Situation ethics at work*. Philadelphia: Westminster.

Guyon, R. (1934). *The ethics of sexual acts*. New York: Knopf.

Guyon, R. (1950). *Sexual freedom*. New York: Knopf.

Money, J. (1986). *Sexosophy and sexology, philosophy and science: Two halves, one whole*. In J. Money, Venuses, penises: Sexology, sexosophy, and exigency theory. Buffalo, NY: Prometheus Books.

Sable, A. (Ed.). (1991). *The philosophy of sex: Contemporary reading.* (rev. ed.) Totowa, NJ: Littlefield, Adams.

Books Sexual Ethics

XIV. **SEXUAL CUSTOM IN HISTORICAL PERSPECTIVE**

Bullough, V.L. (1976). Sexual variance in society and history. Chicago: University of Chicago Press.

Duberman, M. (1990). Hidden from history: Reclaiming the gay and lesbian past. New York: Meridian.

Foucault, M. (1986). The history of sexuality, 3 Vols. New York: Pantheon.

Lewinsohn, R. (1956). A history of sexual customs. New York: Bell Publishing.

Tannahill, R. (1980). Sex in history. New York: Stein & Day.

Taylor, R. (1953). Sex in history. London: Thames & Hudson.

A. Pre-Christian cultures

Dover, K.J. (1978). *Greek homosexuality*. New York: Vintage Books.

Kiefer, O. (1971). *Sexual life in ancient Rome*. London: Abbey Library.

Wood, R. Sex life in ancient civilizations. In Ellis, A. & Abarbanel, A. (1963). *The encyclopedia of sexual behavior*. New York: Hawthorne.

B. Medieval and Renaissance

Gerard, K. and Hekma, G. (1989). The pursuit of sodomy: Male homosexuality in Renaissance and Enlightenment Europe. New York: Harrington Park Press.

C. Eighteenth and nineteenth centuries

D'Emilio J. & Freedman, E.B. (1988). *Intimate matters: A*

history of sexuality in America. New York: Harper & Row.

Katz, J. (1976). *Gay American history: Lesbians and gay men in the U.S*. New York: Avon.

Marcus, S. (1974). *The other Victorians*. (rev. ed.). New York: Basic Books

D. Twentieth century

Bell, A.P., Weinberg, M.S. & Hammersmith, S.K. (1981). *Sexual preference: Its development in men and women*. Bloomington, IN: Indiana University Press.

Comfort, A. (1963). *Sex in society*. London: Gerald Duckworth.

Faderman, L. (1991). *Odd girls and twilight lovers.* New York: Columbia University Press.

Gagnon, J. H. (1977). *Human sexualities*. Glenview, IL: Scott, Foresman.

XV. **CROSS-CULTURAL PERSPECTIVES**

A. Anthropology's contributions to sexology.

Beach, F. (Ed.). (1977). *Human sexuality in four perspectives*. Baltimore: Johns Hopkins University Press.

Frayser, S. (1985). *Varieties of sexual experience: An*

anthropological perspective. New Haven, CT: HRAF Press.

Gregerson, E. (1983). *Sexual practices: The story of human sexuality*. New York: Franklin Watts.

Marshall, D. & Suggs, R. (Eds.). (1971). *Human sexual behavior: Variations in the ethnographic spectrum*. Englewood Cliffs, NJ: Prentice-Hall.

Sherfey, M. J. (1966). *The nature and evolution of female sexuality.* New York: Vintage Books.

Symons, D. (1979). *The evolution of Human sexuality.* New York: Oxford University Press.

1. Limitations. Anthropology has, until recently, generally avoided observation of sexual behaviors except in primitive societies, where the focus has been on sex-related activities such as ritual, initiation ceremonies, socialization and gender roles, symbolism and life cycle stages.

2. Pioneers of anthropological research, studying life in the Pacific islands, learned that Western concepts of feminine and masculine roles were not universal. Early anthropologists learned that the rules for sexual contacts varied from culture to culture.

Ford, C. S. & Beach, F. H. (1951). *Patterns of sexual behavior*. New York: Harper & Row.

Malinowski, B. (1929). *The sexual life of savages in North-western Melanesia*. New York: Halcyon House.

Mantegazza, P. (1932). Anthropological studies of sexual relations of mankind. New York: Anthropological Press.

Mead, M. (1939). From the South Seas. Studies of adolescence and sex in primitive societies. New York: William Morrow.

B. Sexual subjects of anthropological interest

1. Early sexual activity

2.Autoerotic sexual behaviors

3. Premarital sexuality

4. Marriage

Haeberle, E. J. (1983). Marriage in non-western societies, (pp. 436-439). *The sex atlas*. New York: Continuum Publishing.

a) Types of marriage

b) Societal regulations

c) Extramarital sex

d) Post marital sex

5. Homosexuality and bisexuality

6. Ritual sex; tantric

Garrison, O. (1964). Tantra: *The yoga of sex*. New York: Julian Press.

XVI. **EDUCATIONAL SEXOLOGISTS.** Advocacy of sex education has characteristically been met with storms of protest, censorship and violence. The inspiring history of the struggles and achievements of the pioneers of sex education can put into perspective the conflicts of the nineties.

General references

Cassell, C. & Wilson, P.M. (1989). *Sexuality education: A resource book.* New York: Garland.

Moglia, R. (1989-1990). The professional preparation of sexuality educators: A pivotal factor for sexuality education. SIECUS Report, 18(2). 13-15.

A. **PIONEERS OF SEXUALITY EDUCATION**.

1. Margaret Sanger. Opened a birth control clinic, 1916, for which she was imprisoned for "violation of New York State obscenity laws." 1921, founded American Birth Control League, which developed into Planned Parenthood Federation of America.

2. Ben Lindsey. Denver judge, author of The Companionate Marriage (1927), advocated sexuality education and birth control education in public schools and reform of marriage laws.

3. Bertrand Russell. Advocated sexuality education for the young, premarital intercourse, extramarital relations for both women and men, and divorce by mutual consent. His book, Marriage and Morals (1929), dealt with marital and nonmarital sex relations.

4. Albert Ellis. Advocate of sexuality education for all ages, and of a rational view of the varieties of sexual behaviors. Sexuality publications since the fifties include Sex

Without Guilt, The Art and Science of Love, The Encyclopedia of Sexual Behavior (with Abarbanel), The Sensuous Person, many other sex guides and articles and hundreds of lectures on rational sexuality. In 1950, proposed formation of a Society for the Scientific Study of Sex, becoming its first president in 1960.

5. Mary Calderone. In 1964, founded Sex Information and Education Council of the United States (SIECUS). Author of many books and papers on sexuality education; founded SIECUS research library.

6. Ted McIlvenna, Laird Sutton, Maggie Rubenstein and others founded The National Sex Forum in San Francisco, 1968, to develop effective educational methodologies and to provide sexuality education materials that explicitly represent the whole spectrum of human sexual activity. The SAR (Sexual Attitude Restructuring) eight-day program was developed for sexuality professionals and lay persons, and presented annually. Ted McIlvenna also founded the American College of Sexologists.

Haeberle, E. J. (1983). *The sex atlas,* rev. ed. New York: Continuum, 503-511.

7. Patricia Schiller, in 1967, founded The American Association of Sex Educators and Counselors to provide standards in training and education. In 1973 expanded the concept and changed the name of the organization to AASECT to include therapists.

8. Wm. Granzig, in 1986, founded The American Board of Sexology, working with key practitioners in the practice of clinical sexology. Emphasis on clinical practice leads to establishing the term *clinical sexologist*, and the subsequent branching of ABS to include The American Academy of Clinical Sexologists.

Bullough, V.L. (1994). *Science in the bedroom.* New York: Basic Books.

XVII. **SEXUALITY EDUCATION: BIRTH THROUGH PUBERTY.**

Golden, G. (1989). Parental attitudes to infants' sex play determine child's later attitudes to sex. Medical Aspects of Human Sexuality. 73-79.

Gordon, S. (1990). Sexuality education in the 1990's. Health Education, 21(1). Jan-Feb, 4-5.

A. Sexuality education begins at birth through both formal and informal processes and through verbal and non-verbal communication. For young people the four main sources of sex education are family, schools, peers and mass communication and entertainment media. Currently, sexuality education for the young remains one of the most controversial issues in human

sexuality. Among the questions argued are:

1. Where should sexuality education take place - home, school or community? (Sexuality education in the home is rarely adequate.)

2. How much information should be offered to young people?

3. What is age-appropriate information?

4. When and where should sexuality education begin?

B. Sexuality education in the home.

1. Family sexuality education usually involves:

a) Setting and administering rules for permitted behaviors.

b) Defining gender roles, including setting a double standard for sons and daughters.

c) Discussing menstruation with daughters.

2. Families typically either ignore or react negatively to:

a) Childhood genital play

b) Signs of developing sexuality.

c) Childhood development of decision-making skills.

3. Characteristics of ideal family sexuality education:

a) Being "askable parents."

b) Participating in "open listening."

c) Developing good communication skills.

d) Being honest

e) Locating sources of accurate information and resources.

Baldwin, S.E., Baranoski, M.V. (1990), Family interactions and sex education in the home. Adolescence, 25(99). 573-582.

Blank, J. (1983). *A kid's first book about sex.*

Burlingame, CA: Down There Press Books.

Bundy, M.L., White, P.N. (1990) Parents as sexuality educators: A parent training program. Journal of Counseling and Development, 68(3). 321-323.

Calderone, M. S. & Johnson, E. (1981). *Family book about sexuality.* New York: Harper & Row.

Calderone, M. S. & Ramey, J. W. (1982). *Talking with your child about sex.* New York: Random House.

CHOICE & SIECUS. (1983). *Oh no! What do I do now? Messages about sexuality: How to give yours to your child*. New York: SIECUS.

Harris, R. (1994). *It's perfectly normal: Changing bodies, growing up, sex & sexual health.* Cambridge, MA: Candlewick Press.

Wattleton, F., Keiffer, E. & Planned Parenthood (1986). *How to talk with your child about sexuality*. New York: Doubleday.

C. Sexuality education in schools - the questions at issue:

1. How extensive should the information be?

2. At what grade level should sexuality information be introduced?

(1991). *Teaching your children about sexuality.* Washington, DC: American College of Obstetricians and Gynecologists.

3. What qualifications should the sexuality educator have?

4. Should schools provide condoms and other contraceptive devices?

5. What role should parents and communities play in school sexuality education?

Dycus, S. & Costner, G.M. (1990). Healthy early-adolescent development (11-13-year-olds): Implementing a Human Sexuality curriculum for seventh graders. Elementary School Guidance & Counseling, 25(1). 46-53.

Lenskyj, H. (1990). Beyond plumbing and prevention: Feminist approaches to sex education. Gender and Education, 2(2). 217-230.

Mathtech. (1979). *An analysis of U.S. sex education programs and evaluation methods*, Vol. 1. Springfield, VA: National Technical Information Service.

Osborn, A. (1991). "Just Say No" isn't sex education. School Library Journal, 37(4). 39-42.

D. The role of mass communication and entertainment media in scripting attitudes about sex and gender, defining behavior codes - via songs, commercials and ads, film and television.

1. Perpetuating sex role stereotyping; simultaneously projecting imagery of androgyny.

2. Investing market products with sensuality, investing sensuality with priceless exchange value.

3. Casting women in the roles of object and victim.

Himmelweit, H.T. & Bell, N. (1980). Television as a sphere of influence of the child's learning about sexuality. In L. Brown (Ed.), *Childhood sexual learning: The unwritten curriculum*. Cambridge, MA: Ballinger.

E. The sexuality education roles played by peers:

1. Establishing standards of behavior.

2. Perpetuating misinformation.

3. Sharing personal experience.

Thompson, S. (1990). Putting a big thing into a little hole: Teenage girls' accounts of sexual initiation. The Journal of Sex Research, 27(3). 341-361.

F. K-12 sexuality education curriculum should include:

1. Correct names for body parts and sexual behavior (the vocabulary of classrooms and textbooks).

2. Information about masturbation and genital play.

3. Societal rules about nudity.

4. Puberty - anatomic, physiological, psychosocial changes.

5. Conception, pregnancy and childbirth.

National Guidelines Task Force. (1991). *Guidelines for comprehensive sexuality education*. New York: SIECUS.

Pittman, K.J. (1989). Reading and writing as risk-reduction: The school's role in preventing teenage pregnancies. Urban League Review, 12(1-2). 56-69.

6. Contraception.

(1996). Improving the use of contraceptives. Obstetrics and Gynecology. ACOG: Vol. 88, No. 3.

7. Dating relationships, meanings of love.

8. Being sexual - thinking, talking, touching, outercourse, sexual intercourse patterns - safer sex.

Westheimer, R. (1992). *Dr. Ruth's guide to safer sex.* New York: Warner Books.

9. STDs, including HIV/AIDS.

Westheimer, R. (1996). *Sexually transmitted diseases.* Baltimore: American College Health Association.

10. Homoeroticism, homosexuality and bisexuality.

Tripp, C.A. (1975). *The homosexual matrix.* New York: McGraw-Hill.

11. Sexual variations - unusual patterns.

Jacques, T., et al. (1993). *On the safe edge.* Toronto: WholeSM Publishing.

12. Sexual behaviors.

Biehr, B. (1989). Problem sexual behavior in school-aged children and youth. Theory Into Practice, 28(2). 221-226.

Nelson, M. & Clark, K. (Eds.). (1986). *The educator's guide to preventing child sexual abuse*. Santa Cruz, CA: Network Publications.

Soukup, Wickner & Corbett (1984). *Three in every classroom: The child victim of incest-what you as a teacher can do*. Gonvick, MN: Richards Publishing.

XVIII. SEXUALITY EDUCATION

A. The High School Years. Few high schools have sexuality education courses; where they exist they are electives. Sex information makes up a small part of the Health Education course, and, in addition, some information about physiology is taught in biology courses. Quality of teaching varies from poor (where the instructor is particularly uncomfortable about sexuality) to excellent. Instruction usually follows a state-created curriculum.

Adams, C. & Fay, J. (1984). Nobody told me it was rape: A parent's guide to talking with teenagers about *acquaintance rape and exploitation*. Santa Cruz, CA: Network Publications.

Carrera, M. (1981). Sex: The facts, the acts and your feelings. New York: Crown.

Fiedler, J. & Fiedler, H. (1990). Be smart about sex: Facts for young people. Hillside, NJ: Enslow. Grades 7-12.

Gordon, S., Scales, P. & Everly, K. (1979). The sexual adolescent: Communicating with teenagers about sex. N. Scituate, MA: Duxbury Press.

B. College: Human Sexuality 101. There appears to be general consensus about the basic curriculum, and present-day college level sexuality textbooks agree on what is considered basic. However, choice of text is usually up to the instructor and the sales representative, and so some 101 courses use poor, outdated texts which fail to index either HIV, AIDS or chlamydia. Style of presentation varies - from easy reading (for colleges whose students have poor reading skills) to difficult scientific texts considered appropriate for elite universities.

Byer, C. & Shainberg. (1994). *Dimensions of human Sexuality.* Madison, WI: Brown and Benchmark.

Calderwood, D. & Calderwood, M. (1982). Human sexuality textbooks: An experiment in evaluation. SIECUS Report, 10(4). [Establishes standards for comparison.]

Crooks, R. & Baur, K. (1990). *Our Sexuality*, 4th ed. Redwood City, CA: Benjamin/Cummings.

Myerson, M. (1989). Sex equity and sexuality in college level sex education courses. Peabody Journal of Education, 64(4). 71-87.

C. Graduate sexuality programs for the helping professions.

1. Intern training program in sex therapy for pre-doctoral psychology students.
   a) Training consists of ten one-hour lectures on human sexuality and sex therapy. Content is brief; for example, Lecture #9 covers, within one hour: Treating gay and lesbian clients, Transsexualism, and Infertility. No prior sex education is required for admission to this professional training program.

   b) In addition, there are individual and group supervision meetings for discussing the psychology students' treatment of the sexual problems of patients in a private psychiatric hospital. This APA-approved psychology internship has been conducted since 1986.

2. University departments of physical education, health education, counseling, social work and other human services subjects offer courses or integrated programs in human sexuality. Though intended to train students for sex counseling, some of these courses do not require any previous sex education. Universite de Quebec, Kent State and University of Minnesota are some of the institutions offering sexuality-related graduate courses.

Mace, D.R., Bannerman, R.H.O. & Burton, J. (1974). The teaching of human sexuality in schools for health professionals. Public Health Papers, World Health Organization, Geneva.

Welbourne, A.K. (1983). Review of the current status of human sexuality programs for professionals. Marriage and Family Review, 6(3/4). 61-77.

D. Doctoral programs in human sexuality.

Goldstein, B. et al. (1984). Training programs in human sexuality, (pp. 337-345). In R.T. Segraves & E. Haeberle, (Eds.), *Emerging dimensions of sexology: Selected papers from the Sixth World Congress*. New York: Praeger.

1. The Institute for Advanced Study of Human Sexuality, San Francisco. Private non-sectarian graduate school incorporated 1976, with academic programs leading to Masters in Human Sexuality, D.H.S., Ed.D. and Ph.D. in Sexology. The Institute's library system is the most comprehensive sexological library in the world.

The Institute for Advanced Study of Human Sexuality (1989). Catalog. San Francisco, CA: IASHS.

The Institute for Advanced Study of Human Sexuality Alumni Association
http://www.netaccess.on.ca/~sexorg/iashs.htm

The Institute for Advanced Study of Human Sexuality www.iashs.edu

2. New York University, New York, NY. M.S., Ed.D. and Ph.D. programs in human sexuality under aegis of the Department of Health Education. The program prepares individuals to function at the policy-making level in education, research, consultation or counseling.

3. University of Pennsylvania, Philadelphia, has a graduate program in human sexuality education, which is part of the Graduate School of Education. Graduates are prepared for careers as educators, policy makers and researchers.

E. Postdoctoral programs, continuing education programs.

1.The American Academy of Clinical Sexologists, founded in 1991, has inaugurated a program of clinical training that addresses the continuing education needs of clinicians, leads to Board certification and meets state requirements to practice sex therapy in those states having requirements.

2. National and regional meetings of the professional societies (AACS, SSSS, AASECT, SSTAR and others) provide opportunities for continuing education.

3. The National Sex Forum's eight-day SAR is given annually and other institutions throughout the year offer many twelve-hour mini-SARS. They are listed in AASECT's Contemporary Sexuality monthly newsletter.

4. Universities and health profession associations offer conferences on specific sex-related issues. Listed in Contemporary Sexuality and The Society Newsletter of SSSS.

5. SIECUS publishes a list of sex therapy programs, identifying those that provide training opportunities in sex therapy.

F. Helping professionals as providers of sex information.

Rosenzweig, N. & Pearsall, P. (Eds.). (1978). *Sex education for the health professional: A curriculum guide*. New York: Grune Stratton

1. Laypersons and the media expect clinical psychologists to be knowledgeable on the subject of sexuality, though many have no academic sexuality background or experiential preparation. Nonetheless, they provide sex information and attitudes for their clients.

2. Marriage and family counselors, too, are expected to counsel authoritatively, though their education may include little sexual behavior information.

3. Nurses. As sexuality educators, nurses have the advantage of access to clearly written, comprehensive sexuality textbooks that directly address the problems they are apt to meet in their nursing practice.

Fogel, C.I. & Lauver, D. (Eds.). (1990). *Sexual health promotion.* Philadelphia: W.B. Saunders.

4. Mental Health Counselors

5. Clinical Social Workers

6. Physicians

a) The primary care physician is the person most likely to be consulted about a sexual problem. How adequate physicians' sexuality information may be depends on how comfortable they are with their own and others' sexuality and also on how much time they may spare for becoming informed. For some years, sexuality education courses were given in medical schools. But these courses are now being abandoned.

Kolodny, R.C., Masters, W.H., Johnson, V.E. (1979). *Textbook of sexual medicine*. Boston: Little, Brown.

b) Specialists: urologists, gynecologists and psychiatrists. Receive referrals from primary care physicians or internists. Patients have always expected physicians to have broad knowledge of "normal" and problematic sexuality. In many cases, their expectations are not met. Fortunately, there are the specialists who have been intrigued by the problems and gratifications of sexuality and have pioneered and advanced the field of sexology.

7. Religious advisors - priests, ministers, rabbis - are looked to for sexuality information. Leaders of the various denominations have a concerned interest in the control of sexual expression. Position papers instruct congregation leaders on the proper sexual details and beliefs to impart to parishioners in counseling and sermons.

Gordon, S., Scales, P., & Everly, K., (1979). The religious perspective: An overview. In Gordon, Scales, Everly, *The sexual adolescent: Communicating with teenagers about sex*, (2nd ed.). North Scituate MA: Duxbury Press.

Stackhouse, B. (1989). The impact of religion on sexuality education. SIECUS Report, 18(2). 21-24, 27.

G. Community programs.

1.Sex Information and Education of the United States (SIECUS)

a) Provides consultant services to communities and schools, supports a nationwide program of sex education. Publishes pamphlets, bibliographies, and the quarterly SIECUS Report, maintains a research library.

b) Responds to phone and mail questions from laypersons and professionals about sexuality and resources.

2. Planned Parenthood Federation of America

a) Established 1942, provides reproduction information and voluntary birth control information to the general public. Over 200 affiliates in the U.S.

b) Publishes books and pamphlets on reproductive health, maintains a sex information research library.

3. City Health Departments.

a) The AIDS Training Institute, New York City Department of Health, Division of AIDS Program Services. Established 1988 to help meet needs of service providers whose work demands that they be current and culturally sensitive about AIDS and HIV infection. Helps participants become effective in promoting risk reduction among clients at risk for HIV infection.

b) Courses in Safer Sex, Adolescents and HIV, Drugs and HIV, Tuberculosis and HIV, Latino Awareness, Women and HIV, Hepatitis, Alcoholism, STDs and more.

Catalog of Training (1991). ATI, NYC Dept. of Health, New York, NY.

4. Community sex information hotlines.

a) Hotlines, which offer, by telephone, straight-forward information and referral resources about sex, have a short past and a problematic future. In the cities where they have appeared, they are the product of a grass roots effort by concerned health workers rather than civic agencies.

b) San Francisco Sex Information. Formed in 1972 by Toni Ayres, Carolyn Smith and Maggie Rubinstein. Still serving the Bay Area in the nineties.

c) Los Angeles Sex Information. Formed and funded in 1973 by the Los Angeles Free Clinic. Still active in 1992.

Alman, I. (1992). *Sex information: May I help you?* Burlingame CA: Down There Press. (Originally published as Aural Sex & Verbal Intercourse, 1984.)

Frisher, K.L. (Ed.). (1976). *Sex counseling by telephone*. Cambridge: Preterm Institute, Schenkman Publishing.

Rila, M. (Ed.), (1990). *San Francisco Sex Information Training Manual*. San Francisco: S.F.S.I.

5. Hotlines providing information on specific subjects:

a) AIDS: 1-800-342-AIDS, information provided by Centers for Disease Control.

b) Safe Sex and AIDS, for teens: 1-800-234-TEEN. Information provided by teens, Monday-Friday, 4-8 pm, CST.

c) STDs: 1-800-227-8922. Maintained by American Social Health Association.

d) Abortion: 1-800-772-9100. National Abortion Federation for referrals.

e) Sexual violence: 1-212-577-7777, victim's service hotline provided by New York Women Against Rape.

f) Referral to a clinical sexologist or sex therapist. American Board of Sexology. 1-202-462-2122.

6. Programs of religious and cultural groups.

a) Sunday sex information classes for young people. The program designed for the Universalist Unitarian Church is an outstanding example.

b) Programs for adult groups.

7. Sexuality education for people with developmental disabilities.

Cole, S. & Cole, T. (1993). Sexuality, disability and reproductive issues through the lifespan. Sexuality & Disability, 3(3).

Healy, A. & Smith, B. (1982). *Sex education for individuals with developmental disabilities: An annotated bibliography.* Iowa: Division of Developmental Disabilities of University Hospital School.

Kempton, W. (1990). *Sex education for persons with disabilities that hinder learning: A teacher's guide.* Santa Monica, CA: James Stanfield.

a) Sexual rights and the importance of sex education in the habilitation process.

Ames, T.R.H., Hepner, P.J., Kaeser, F. & Pendler, *Sexual rights of persons with developmental disabilities: Guidelines for programming with severely impaired persons*. New York: Coalition on Sexuality and Disability.

Lippin, D.S. & Randall, D.E. (1986). Personal growth and development: A family life education manual for special education. New Jersey: Lippin & Randall Publications.

b) Profoundly retarded persons can learn and take responsibility for functional sexual behaviors.

c) Opportunity for privacy and choice of partners must not be denied categorically on basis of "capacity to consent" legal ramifications.

The Young Adult Institute Education and Training Department. *AIDS; Teaching people with disabilities to better protect themselves*. New York: YAI.

H. Curriculum theory and design.

1. Kindergarten to twelfth grade: key concepts, as developed by the National Guidelines Task Force, 1991.

a) Human development - physical, emotional, social and intellectual growth.

b) Relationships - of central importance throughout life.

c) Personal and interpersonal skills - for a rewarding sexual life.

d) Sexual behavior - how sexuality is expressed in a variety of ways throughout life.

e) Sexual health - requires specific information and attitudes in order to avoid unwanted consequences of sexual behavior.

f) Society and culture - the way people learn about sex and act sexually is shaped by their environment.

Bruess, C.E. & Greenberg, J.S. (1988). *Sex education: Theory and practice*, (2nd ed.). Belmont, CA: Wadsworth Publishing.

National Guidelines Task Force. *Guidelines for comprehensive sexuality education: Kindergarten - 12th grade*. New York: SIECUS.

2. Sex Respect - "Pet your dog, not your date," a conservative Christian sexuality curriculum taught in 1500 schools.

3. Human Sexuality 101. In the early eighties a group of NYU Human Sexuality Program students and faculty drew up a curriculum for college level sexuality courses. In the nineties, safer sex and HIV/AIDS were important additions to the curriculum.

Calderwood, D. & Calderwood, M. (1982). Human sexuality textbooks: An experiment in evaluation. SIECUS Report, 10(4).

4. Doctoral program curricula. In 1976 core curricula for the Ph.D. in Human Sexuality and the Ed.D. in Human Sexuality were drawn up by the faculty of The Institute for Advanced Study of Human Sexuality. These curricula have become models for the Doctoral Programs in Human Sexuality directed by university health education departments.

Catalog of The Institute for Advanced Study of Human Sexuality, (1989). San Francisco: IASHS.

The Institute for Advanced Study of Human Sexuality
http://www.netaccess.on.ca/~sexorg/iashsd.htm

H. Communication and entertainment media as providers of sex information.
1. Television, radio and films

a) Soaps, TV dramas. Instruction through example, presenting models (some good, some bad) for initiating sexual interaction.

b) Videos. Becoming the most effective medium for conveying information and misinformation, and for creating behavior models.

1) Sex education. Videos are distributed to institutions and individuals. Some important sources are:

(a) MultiFocus, San Francisco, 800-821-0514

(b) The Sexuality Library, 415-550-7399

(c) Focus International, 800-843-0305, 14 Oregon Drive, Huntington Station, New York, NY 11746-2627.

2) Entertainment

c) TV talk shows, radio call-in programs, panel shows. Talk shows offer opportunities to hear first-person descriptions of varied lifestyles, sexual patterns and problems.

2.Periodicals

a) General circulation magazines and newspapers. Report on incidents of sexual violence, health related sexual topics and biomedical research.

b) Women's home and workplace magazines. Offer instructions for eroticizing marital and other relationships.

c) Men's sex and advertising-medium magazines

Winick, C. (1985). A content analysis of sexually explicit magazines sold in an adult bookstore. The Journal of Sex Research. 21(2). 206-210.

3.Sex manuals and textbooks

Campbell, P. (1987). Sex guides: Books and films about sexuality for young adults. New York: Garland Publishing.

Religious publishing companies produce and sell vast numbers of dating manuals and sex prevention guides, dwarfing the circulation of the standard non-religious sexuality manuals (such as Eric Johnson's perennial best seller, *Love and sex in plain language*). They are distributed through religious bookstores and rarely appear in the libraries. As might be expected, these books are, by definition, moralistic and do not typically present a complete guide to sexuality.

f.a.c.t. book committee. (1986). *Caught looking: Feminism, pornography & censorship*. New York: Caught Looking Inc.

Penthouse Forum. New York: Forum International.

Short, R.E. (1978). *Sex, love or infatuation: How can I really know?* Minneapolis: Augsburg Publishing House.

van de Velde, T.E. (1965). *Ideal Marriage*. New York: Random House.

4. Rock 'n' roll lyrics, rap music, music video.

a) Provide sexuality models for pre-teens and teens.

b) Mixed messages: androgyny, macho, sexual violence, romance, and the sex/drug connection.

Chapter 2

THE MEDICAL PERSPECTIVE

The medicalization of sex includes both the physical knowledge of anatomy and physiology and the contradictory efforts of the medical community to both pathologize sexual behavior, i.e. Dr. Samuel Tissot's masturbation theories, and to ameliorate sexual problems, i.e., Masters and Johnson's work on sexual inadequacies. The medical model of human sexuality has often lacked scientific support. Morality has been confused with tradition. In reviewing the medicalization of sexual behaviors it must be concluded that many particular acts that have been deemed unhealthy are, in fact, normative sexual behaviors.

Bullough, V. L. (1994). *Science in the bedroom: A history of sex research*. New York: Basic Books.

Nuland, S.B. (1999). *The mysteries within: A surgeon reflects on medical myths*. New York: Simon & Schuster.

Ridley, M. (1999). *Genome: The autobiography of a species in 23 chapters.* New York: HarperCollins.

I. SEXUAL DIFFERENTIATION

A. Forty-six chromosomes in all cells except sperm and ovum cells that contain twenty-three chromosomes**.**

B. Gamete (sex cells).

1. Ovum – x chromosome.
2. Spermatozoon (sperm) – x or y chromosome.

C. Fertilization – in the fallopian tubes the gametes each containing twenty-three chromosomes combine to produce a zygote containing forty-six chromosomes:

1. Female xx. (ovum x, sperm x).
2. Male xy. (ovum x, sperm y).

D. Embryonic Development (8 weeks).

1. Two sets of interior sexual organs located in the lower abdomen behind the bladder are:
    a. Wolfian duct – male.
    b. Mullerian duct – female.

c. Sex gland.
d. Genital tubercle.

E. Dimorphic development of the genitalia.

1. Female – xx chromosomes.
    a. Mullerian duct develops into a uterus and fallopian tubes connected to sex glands, which become ovaries.
    b. Genital tubercle becomes the clitoris nestled at top of labia.
    c. Wolfian duct shrivels up and remains on top of ovaries.
    d. Fetus is a fully developed female.

2. Male – xy chromosomes. (Gene on the top of the short arm of the y called TDF, Testis Determining Factor).
    a. Testes descending hormone secretes and turns the sex gland into testes – which descend to between the legs.
    b. Genital tubercle becomes the penis.
    c. Testes produce testosterone to develop the Wolfian duct into the seminal vesicle and vas deferens.
    d. Mullerian Inhibiting Hormone (MIH) to kill off the Mullerian duct – to lead to masculinization and defeminization.

F. Fetal development of the brain.

1. Female xx develops.
2. Male xy – MIH defeminizes and masculinizes the brain.

A. Sexual Anatomy

Dickson, R. L. (1949). *Human sex anatomy: A topographical hand atlas,* (2nd ed.). Baltimore: Williams and Wilkins.

Mims, F. S. & Swenson, M. (1980). *Sexuality: A nursing perspective*. New York: McGraw Hill.

Kahn, L.D. (1997). The Grafenberg Spot. Cliniscope, No. 3. Washington, DC: American Academy of Clinical Sexologists.

Netter, F. H. (1965). *The Ciba collection of medical illustrations, Vol. 2: The reproductive system*. New York: Ciba.

A. Female genitals

Blank, J. (Ed.). (1993). *Femalia.* Burlingame, CA: Down There Press.

Boston Women's Health Book Collective. (1984). *Our bodies, ourselves,* (3rd ed.). New York: Simon and Schuster.

The Diagram Group. (1978). *Woman's body: An owner's manual.* New York: Bantam.

Sevely, J. L. (1987). *Eve's secret: A new theory of female sexuality.* New York: Random House.

1.External genitals - Vulva

a) Labia majora
b) Labia minora
c) Clitoris
d) Mons pubis
e) Perineum

2.Internal genitals

a) Hymen
b) Bartholin's glands
c) Vagina
d) Cervix
e) Uterus
f) Fallopian tubes
g) Ovaries (and menstrual cycle)

Delaney, J., Lufton, M. J. & Toth, E. (1988). *The curse* Urbana, IL: University of Chicago Press.

Haeberle, E. J. (1983). *The human body, 3-51, The sex atlas,* rev'd & expanded. New York: Continuum.

Ladas, A.K., Whipple B. & Perry, J. (1982). *The G spot.* New York: Holt, Reinhart & Winston.

h) G spot

3. Male genitals

The Diagram Group. (1976). *Man's body: An owner's*

manual. New York: Bantam.

Toguchi, Y. & Weisbrod, M. (Ed.). *Private parts: A doctor's guide to the male anatomy.* New York: Doubleday.

a) External genitals

(1) Penis and circumcision

(2) Scrotum

b) Internal genitals

(1) Testes and spermatogenesis

(2) Epididymides

(3) Vasa deferentia

(4) Seminal vesicles

(5) Prostrate gland

(6) Ejaculatory ducts

(7) Cowper's glands

C. The brain

D. The skin

Development of the Human Body
http://www.public.asu.edu/~ide4bubu/sexlinks/body.html

Fischer, Helen. (1997). *Anatomy of Love.* New York: Fawcett Books.

II. **SEXUAL PHYSIOLOGY**

A. Sources of sexual arousal.

Gagnon, J. H. (1977). Ch. 7: Sexual arousal and response, 117-139*, Human sexualities.* Glenview, IL: Scott, Foresman.

B. Models of sexual response cycle. A four-phase model of human sexual response as described by Albert Moss in 1909 and Wilhelm Reich in 1942. The Function of the Orgasm. This model was renamed and elaborated on by Masters and Johnson in 1966. The Masters and Johnson model has achieved semi-official status in textbooks. Other sexologists, including Curtis, Ellison, Kaplan, Schnarch and Zilbergeld, have proposed other models.

1.The Masters and Johnson four-phase model of the human sexual response differentiates physiological stages marked mainly by increase and decrease in vasoconstriction and myotonia. [Landmark in sex research; based on laboratory study of physiological aspects of human sexual response cycle.

Masters, W. H. & Johnson, V.E. (1966). *Human sexual response.* Boston: Little, Brown.

a) Excitement phase

(1) In female, clitoris enlarges and becomes more sensitive. Lubrication of vagina results from "sweating" (transudate), and inner two-thirds balloons. Breast size increases; nipples become erect and more sensitive. Heart rate and blood pressure increase.

(2) In males, tumescence and erection of penis occurs. Scrotal sac thickens, testes elevate. Nipples may become erect and more sensitive. Heart rate and blood pressure increase.

b) Plateau phase

(1) In female, with continuing stimulation, clitoris retracts beneath the clitoral hood. Vasoconstriction increases in outer third of vagina, labia minora enlarges and changes from red to deep wine color. Elevation of uterus and cervix causes "tenting" effect (or ballooning of inner third of vagina). Bartholin glands release drops of secretions. Sex flush of abdomen and chest may occur.

(2) In male, penis width increases at coronal ridge; testes elevate and increase in size. Cowper's glands release drops of secretion. Sex flush may appear.

c) Orgasm phase

(1) In female, orgasmic platform (outer third of vagina) contracts rhythmically, rectal and urethral sphincters contract. Some women experience emission of a secretion.

(2) In male, there is a sensation of ejaculatory inevitability before orgasm. Perineal muscles contract rhythmically, and prostrate, seminal vesicles and urethra contract, causing semen emission.

d) Resolution

(1) In female, detumescence causes clitoris to return to normal position. Labia return to original shape and size with decreasing vasocongestion. Unlike the male, there is no refractory period, and with continuing stimulation, more orgasms may occur.

(2) In male, penis usually returns to flaccid state. Muscles relax, testes descend. A refractory period occurs.

2.Triphasic model. Kaplan's model of the human sexual response: Unlike the excitement and orgasm phases, which are marked by measurable physiological signs (mainly vasoconstriction and myotonia), desire is a state that is subjectively experienced and reported. It may or may not be present during the sexual response, and if present, desire may not end before the excitement phase, but continue past the orgasm phase.

a) Desire phase

b) Excitement phase

c) Orgasm phase

Kaplan, H.S. (1979). Disorders of sexual desire and other new concepts and techniques in sex therapy. New York: Brunner/Mazel.

C. Hormones and sexuality

Ciba Foundation. (1979). *Sex, hormones & behavior.* Amsterdam: Excerpta Medica.

1. Hormones and sexual functions

2. Puberty

Katchadurian, H. (1977). *The biology of adolescence.* San Francisco: Freeman.

3. Hormones and atypical behavior

Money, J. & Erhardt, A. (1972). *Man & woman, boy & girl.* Baltimore: Johns Hopkins University Press.

4. Hormones and sexual behavior

Kelley, K. (Ed.). (1987). *Females, males, and sexuality.* Albany: State University of New York Press.

D. Roles of the nervous system in sexual response. The role of neuroendocrine factors in sex experience. Neurophysiological mechanisms that regulate function.

Davidson, J. M. (1980). The psychobiology of sexual experience. In J.M.Davidson and R. Davidson, (Eds.), *The psychobiology of consciousness.* New York: Plenum.

Thompson, R.F. (1985). *The brain*. New York: W.H. Freeman.

Human Body, Hormones
http://www.public.asu.edu/~ide4bubu/sexlinks/body.html

III. **SEXUAL REPRODUCTION**

A. Conception

Demarest, R. & Sciarra, J. (1969). *Conception, birth and contraception,* (2nd ed.). New York: McGraw-Hill.

B. Pregnancy

Engel, N.C. (1990). The maternity cycle and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W. B. Saunders.

Planned Parenthood of Alameda. (1985). *The complete guide to pregnancy, testing and counseling.* San Francisco: Planned Parenthood of Alameda.

C. Birth

Ingelman-Sandberg, A., Wirsen, C. & Nilsson, L. (1980). *A child is born,* (2nd ed.). New York: Delacorte. [Embryo development, pregnancy and childbirth - in photographs and text.]

D. Postpartum

E. Problem pregnancies

F. Infertility

Harkness, C. (1987). The infertility book: A comprehensive medical and emotional guide. San Francisco: Volcano Press.

The Kinsey Institute for Research in Sex, Gender and Reproduction
http://www.indiana.edu/~kinsey/

IV. **CONTRACEPTION: METHODS OF BIRTH CONTROL**

American College of Obstetricians and Gynecologists (1988). *Sterilization.* Technical Bulletin No. 113. Washington, DC: ACOG.

Contact: American College of Obstetricians and Gynecologists, Resource Center, 409 12th Street NW, Washington, DC 20024-2188.

Everett, J. & Glanze, W. D. (1987). *The condom book: The essential guide for men & women.* New York: New American Library.

Gilette, P. (1972). *Vasectomy: The male sterilization option*. New York: Warner Library.

Hatcher, R., Guest, E., Stewart, F. Stewart, G.K., Trussell, J., Cerel, S. & Cates, W. (1990).

Contraceptive technology 1990-1991. Atlanta, GA: Printed Matter.

Kalma, S.H. & Lauver, D. (1990). Contraception and sexuality, 206-267. In C.I. Fogel & D. Lauver, Sexual *health promotion.* Philadelphia: W.B. Saunders.

Luckman, J. & Sorensen, K.C. (1988). *Medical- surgical nursing,* (3rd ed.). Philadelphia: W.B. Saunders.

Shapiro, H.I. (1988). *The new birth control book: A complete guide for women and men.* New York: Prentice Hall.

A. Hormones

1. Birth control pills

2. Implants

3. Injections

4. Morning-after pill

B. Intrauterine Device (IUD)

C. Barrier Methods

1. Diaphragm

2. Condom

3. Cervical cap

4. Spermicides

a) Vaginal cream

b) Jelly

c) Foam

d) Film

e) Suppositories

D. Withdrawal

E. Natural family planning

F. Sterilization

1. Tubal ligation

2. Vasectomy

G. Abstinence

V. **PREGNANCY TERMINATION**

A. "Morning after" pill

B. Menstrual extraction and other methods

C. Abortion

Mishell, D.R., Jr. (1992). Contraception, sterilization and pregnancy termination. In A.L. Herbst, D.R. Mishell, Jr., M.A. Stenchever, & W. Droegemuller, (Eds.), Comprehensive *gynecology,* (2nd ed.). St. Louis: Mosby, 335-336.

D. RU-486: Requires three (3) visits to a clinic:

1. Initial dose - within seven (7) weeks of gestation

2. Second dose - next day with four (4) hour observation

3. Final dose - 12 days later with examination

Couzinet. B. (1986). Termination of early pregnancy by the progesterone antagonist RU-486 (mifepristone.) New England Journal of Medicine, Dec. 19, 315(25). 1565-1569.

VI. **WOMEN'S SEXUAL HEALTH ISSUES**

A. Body image (how a woman perceives herself and how she believes others perceive her); mental and emotional health.

B. Nutrition

C. Exercise

D. Stress management

E. Drug use and abuse

F. Satisfactory environment and occupation, egalitarian treatment in the workplace and freedom from sexual harassment and abuse

G. Sexual preference and relationships

Tully, C. (1995). *Lesbian social services.* Binghamton, NY: Haworth.

H. Contraception, conception, pregnancy and birth. Women's health issues; answers to questions on variety of topics from abortions to yeast infections. Provide options and recommendations for making informed decisions armed with research findings on breast implants, hysterectomy, C-section, the Pill and others.

Gordon, S. & Snyder, C.W. (1989). Personal issues in

human sexuality: A guidebook for better sexual health. Boston: Allyn & Bacon.

Wolfe, S.M. (1991). Women's health alert. New York: Addison-Wesley Publishing.

I. Women's self-care.

1. Self-examination of the genitalia and anus.

2. Self-care of the genitalia

3. Self-examination of the breasts.

Tyrer, L. and Granzig, W. (1976). Instructing patients in self-examination of the breast. Clinical Obstetrics and Gynecology (18)2. 175-186.

J. Medical care.

1.Endometriosis

2.Dyspareunia

(1992). Pain during intercourse. ACOG Patient Education, (APO 20). Washington, DC: ACOG.

Glatt, A.E., et al. (1990). The prevalence of dyspareunia. Obstetrics and Gynecology, 75(3), part 1.

3. Hormone replacement therapy

(1997). Midlife transitions: A guide to approaching menopause. ACOG Patient Education, (APO 13). Washington, DC: ACOG.

4. Routine gynecological exam, beginning at age 18 (or earlier if sexually active with a partner).

5. Schedule for examinations as suggested by the American Cancer Society. Emphasizes educating women for knowledgeable participation in their own health decisions and care.

Littlefield, V.M. (1986). Health education for women: A guide for nurses and other health professionals. Norwalk, CT: Appleton-Century-Crofts.

(1989). Standards for obstetric-gynecologic services, 7th ed. Washington DC: American College of Obstetricians and Gynecologists.

VII. **MEN'S SEXUAL HEALTH ISSUES**

Reinisch, J.M. & Beasley, R. (1990). The Kinsey Institute new report on sex: What you must know to be sexually literate. New York: St. Martin's Press. 413-424.

Books Safer Sex/STDs
http://www.drruth.com:80/picks/books/safer.html

Sexually Transmitted Diseases
http://www.public.asu.edu/~ide4bubu/sexlinks/stds.html

A. Men's self-care. Self-examination of scrotum, testes, and breasts. Preventative health care; importance of making informed choices about one's body.

Swanson, J.M. & Forrest, K.A. (1984). *Men's reproductive health*. New York: Springer Publishing.

B. Medical care.

1. Annual prostate examination at age 40 (preferably by urologist), DRE-digital rectal examination.

2. Prostate-specific antigen (PSA) blood test.

Oesterling, J.E. (1991). The role of PSA in detecting prostate cancer. Medical Aspects of Human Sexuality 25(7). 22-27.

3. Ultrasound analysis. A recent approach to analyzing ultrasound images of the prostate gland, developed by Dr. Nancy S. Hardt, assistant professor of pathology at the University of Florida College of Medicine, is now a standard test in early detection of prostate cancer.

Chapter 2

Part Two - The Health Perspective: AIDS/HIV and Other STDs

I. **HIV/AIDS**. We live in a new age - the Age of AIDS. The continuing spread of this disease requires that we follow new guidelines regarding sex in our lives and in the lives of our clients and

students, and to become alert to new risks in the use of alcohol and other drugs.

General references

Abstracts from the International AIDS Conferences, I-VIII. American College Health Association Newsletter.

Katchadourian, H.A. (1989). AIDS and the human immunodeficiency virus. In H.A. Katchadourian, *Fundamentals of human sexuality*, (5th ed.). Ft. Worth: Holt, Rinehart & Winston. 132-145.

Kerrins, J. & Jacobs, G. W. (1989). T*he AIDS file* (2nd ed.). Woods Hole, MA: Cromlech Books.

Koop, C.E. (1986). *Surgeon General's report on acquired immune deficiency syndrome*. Washington, DC: U.S. Public Health Service.

A. Definitions:

1. HIV

a) HIV is an acronym for Human Immunodeficiency Virus

b) HIV is a member of the retrovirus group; it invades and replicates inside the human helper T cell and the macrophage.

c) It causes collapse of the immune system.

d) When the body's immune system is ineffective, opportunistic diseases are able to develop.

2. AIDS.

a) AIDS is an acronym for Acquired Immune Deficiency Syndrome

b) CDC diagnostic definition was based on cases observed in early eighties. AIDS may be diagnosed in anyone who tests HIV+, has symptoms suggesting cellular immune deficiency and one of the opportunistic diseases. The official CDC diagnostic definition is complex and specific.

Mass, L. & Grochowski, J. (Ed.). (1987). *Medical answers about AIDS*. New York: Gay Men's Health Crisis.

c) AIDS was to be redefined 1992, at which time it would include many more individuals than under the present definition.

d) Most common AIDS/HIV diseases and malignancies:

(1) PCP: Pneumocystis carinii pneumonia, a protozoan infection of the lungs.

(2) KS: Kaposi's sarcoma, a malignant tumor of blood and lymphatic vessel wall tissues.

Toxoplasma gondii
Cryptosporidium
Candida species
Cryptococcus neoformans
Mycobacterium avium-intracellulare
Mycobacterium tuberculosis
Cytomegalovirus
Herpes simplex
Herpes zoster
Epstein-Barr virus
Idiopathic thrombocytopenia purpura (ITP)

Centers for Disease Control. Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome. MMWR (1987): (15):4S-5S.

3. ARC, now called Category 3 (of the course of infection)

a. ARC is an acronym for AIDS-Related Complex

b. ARC (or Category 3) is an early stage of HIV infection that falls short of meeting the CDC case definition of AIDS.

B. Origins and history

Shilts, R. (1987). *And the band played on*. New York: St. Martin's Press. [On the political history of AIDS/HIV.]

1. Epidemiology

Guinan, M.E. & Hardy, A. (1987). Epidemiology of AIDS in women in the United States, 1981-1986. Journal of the American Medical Association, 257. 2039-2042.

Scientific American (1988). 259(4). October.

2. Modes of transmission

a) Exchange of body fluids at sexual contact

b) Exchange of blood via needle sharing and other skin piercing acts

c) Exchange of blood via transfusion, as for hemophilia

d) From mother to child before or after birth

C. Risk reduction strategies

McIlvenna, T. (Ed.). (1987). *The complete guide to safe sex.* San Francisco: Specific Press.

1. Safer Sex-protected sexual contacts: especially condom + nonoxynol-9 + foam or sponge.

2. Safe Sex-other issues

a) Techniques for reducing risk in needle use - cleaning works with household bleach

b) Reduction in use of drugs

c) HIV testing and family planning

d) Precautions for health workers

D. AIDS Risk Assessment Paradigm.

Granzig, W. (1993) University of Florida College of Medicine. Obstetric-Gynecologic Conference. University Hospital, Jacksonville.

Risk factor 0 - No risk
Risk factor 1 - Very low risk
Risk factor 2 - Low Risk
Risk factor 3 - high risk, unsafe and dangerous practice, especially to the highest risk participant.

ACTIVITY	RISK	HIGHEST	LESSER
Abstinence	**0**	**None**	**None**
Intercourse, unprotected	**3**	**Receptor**	**Inserter**
Anal intercourse with condom	**2**	**Receptor**	**Inserter**
Anilingus, latex dam	**1**	**Inserter**	**Receptor**
Anilingus, unprotected	**2**	**Inserter**	**Receptor**
Biting/nibbling/licking unbroken skin	**0**	**None**	**None**
Body massage/rubbing	**0**	**None**	**None**
Bondage	**0**	**None**	**None**
Breast, manual stimulation	**0**	**None**	**None**
Breast, oral stimulation	**0**	**None**	**None**
Cunnilingus, unprotected (not menstruating).	**1**	**Neither**	**Neither**

Digital, anal sex with glove	1	Receiver	Inserter
Digital, anal, unprotected	2	Receiver	Inserter
Discipline	0	None	None
Douching equipment, personal	0	None	None
Douching equipment, shared	3	Both	Both
Enema equipment, personal	0	None	None
Enema equipment, shared	3	Both	Both
Fellatio with ejaculation, unprotected	2	Active	Passive
Fellatio with ejaculation, with condom	1	Active	Passive
Fellatio without ejaculation	1	Active	Passive
Fingers, anal, unprotected	2	Receiver	Inserter
Fingers, anal, latex glove	1	Receiver	Inserter
Fingers, vagina, unprotected	1	Receiver	Inserter
Fingers, vagina, latex glove	1	Receiver	Inserter
Fist, vagina, latex glove	1	Receiver	Inserter
Fist, vagina, unprotected	2	Receiver	Inserter
Fisting, unprotected	2	Receiver	Inserter
Fisting, with latex glove	1	Receiver	Inserter
Flagellation	0	None	None
Flogging	0	None	None
Frottage	0	None	None
Hugging	0	None	None
Interfemoral intercourse	0	None	None
Kissing, dry	0	None	None
Kissing, French, wet	1	Both	Both
Licking on healthy clean skin	0	None	None
Manual vaginal intercourse, unprotected	2	Receptor	Inserter
Manual vaginal intercourse, with latex glove	1	Receptor	Inserter
Massage	0	None	None
Masturbation, mutual	1	None	None
Masturbation, solo	0	None	None
Menstrual blood sharing	3	Both	Both
Nocturnal emission	0	None	None
Oral anal, latex dam	1	Inserter	Receptor
Oral anal, unprotected	2	Inserter	Receptor
Petting	0	None	None
Prostitute, fellatio, unprotected w/ejaculation	2	Active	Passive
Prostitute, fellatio, with condom w/ejaculation	1	Active	Passive
Prostitute, vaginal intercourse, unprotected	3	Woman	Man
Prostitute, vaginal intercourse with condom	2	Woman	Man
Receiving semen vaginally without condom	3	Woman	Man
Rimming, latex dam	1	Inserter	Receptor
Rimming, unprotected	2	Inserter	Receptor
S & M scenes without bruising or bleeding	1	None	None
Sensuous feeding	0	None	None
Sex toys, personal	0	None	None

Sex toys, shared	**3**	**Both**	**Both**
Sharing needles or blood while shooting drugs	**3**	**Both**	**Both**
Smelling bodies and body fluids	**0**	**None**	**None**
Steroid needle sharing	**3**	**Both**	**Both**
Swallowing semen	**2**	**Swallower**	
Tasting your own body fluids	**0**	**None**	**None**
Urine, external	**1**	**Receiver**	
Urinating, mouth or on broken skin	**2**	**Receiver**	
Vaginal intercourse, unprotected	**3**	**Woman**	**Man**
Vaginal intercourse, with condom	**2**	**Woman**	**Man**
Water sports, external	**1**	**Receiver**	
Water sports, in mouth or on broken skin	**2**	**Receiver**	
Wet dream	**0**	**None**	
Whipping, without bleeding	**0**	**None**	

E. Testing issues

1. Advisability of testing: pros and cons

2.Anonymity and confidentiality issues, legal guidelines

3. Counseling pre-test and post-test; follow-up

Megallon, D.T. (1987). Counseling patients with HIV infections. Medical Aspects of Human Sexuality, 21. 129-147.

American College of Obstetricians and Gynecologists. (1991). Voluntary Testing for Human Immunodeficiency Virus. ACOG Committee Opinion 97. Washington DC: ACOG.

F. Treatment modalities

(1997). Report of the NIH panel to define principles of HIV infection. Washington, DC: National Institute of Health.

1. Lifestyle changes: diet, rest, exercise and reduction of immune suppressant behaviors.

2.Prophylactic AZT and pentamidine, DDI

3. Symptomatic and syndrome approaches to opportunistic diseases

Mass, L.D. & Grochowski, J. (Ed.). (1987). *Medical*

answers about AIDS. New York: Gay Men's Health Crisis.

G. Support groups for:

1. HIV+ continuum

2. Families and loved ones

3. AIDS care providers - educators, counselors, direct service people such as those with GMHC, SHANTI, OPEN HAND

4. Death and dying education

Griggs, J. (Ed.). (1989). *Simple acts of kindness: Volunteering in the age of AIDS*. New York: United Hospital Fund of New York.

II. **OTHER SEXUALLY TRANSMITTED DISEASES**

Tseng, C. H., Villanueva, T. G. & Powell, M. D. (1987). *Sexually transmitted diseases: A handbook of protection, prevention, and treatment*. Saratoga, CA: R & E Publishers.

STD & Causative Agent	**TRANSMISSION** (Body Fluids and/or Direct Contact)	**SYMPTOMS**
Chlamydia *Chlamydia trachomatis* (an unusual intracellular bacteria)	**Fluids --** contact of mucous membranes (cervix, urethra) with infected person's fluids (semen and mucus). Transmission most common with exposure through vaginal or anal sex. Casual contact considered to be safe.	Most patients with chlamydia have no symptoms. If present, they may be: Women -- pain or dull aching from cervix, heavy feeling in pelvic area, pain with urination or intercourse, heavier menstrual flow, breakthrough bleeding, heavy cervical discharge. Men -- urethral discharge, pain with urination, epididymitis.
HPV/Genital Warts/ Intraepithelial Neoplasia *Human Papillomavirus* (about 1/3 of over 70 HPV types)	**Contact** -- touching an infected person's lesions can transmit cells containing the virus. Penetrative intercourse or even genitaVgenital touching is not necessary	Usua}ly no symptoms, but extemal lesions may itch. Lesions on the skin can be either papillary (standing up from the skin) or flat. Lesions on the cervix can be seen only with the use of 5% acetic acid and magnification.
Herpes Simplex (HSV) *Herpes Simplex Virus* (both types I & II)	**Contact** -- touching an infected person's lesions can transmit cells containing the virus. Penetrative intercourse or even genital/genital touching is not necessary. Recent reports suggest that transmission	Single or multiple vesicles (fluid-filled blisters) appear anywhere on genital skin. They rupture, leaving extremely painful shallow ulcers. They heal in about 12 days.

	can occur in the absence of lesions.	
Molluscum Contagiosum *Molluscum Contaglosum Virus* (a member of the pox virus group)	**Contact** -- touching an infected person's lesions can transmit cells containing the virus. Penetrative intercourse or even genital/genital touching is not necessary.	Small, round, raised lesions with a shiny surface and white material inside, located on genital skin and also thighs,abdomen, and even chest. Usually no symptoms, but may itch. May become secondarily infected with bacteria.
Pelvic Inflammatory Disease (PID) Initially with *Chlamydia trachomatis* or *Neisseria gonorrhoeae.* May "simmer" for years but when infection is termed PID it is polymicrobial (anaerobes, facultative bowel bacteria, *Mycoplasma hominis* and a variety of other bacteria).	Fluids -- contact of open skin or mucous membranes with infected person's body fluids (mucus, semen). Transmission most common with exposure through oral, anal, or vaginal sex. Casual contact considered to be safe.	May be asymptomatic even at this stage, but usually characterized by moderate to severe lower abdominal pain (unilateral or bilateral), fever, chills, and possibly bowel symptoms. May mimic appendicitis, utereal stones, twisted or ruptured ovarian cyst, and other acute lower abdominal conditions.
HIV/AIDS *Human Immunodeficiency Virus*	Fluids -- contact of open skin or mucous membranes with infected persons body fluids (blood, mucus, semen). Transmission most common with exposure through oral, anal, or vaginal sex. Casual contact considered to be safe. Health care workers at particular risk through knife cuts and needle sticks.	Divided into four stages: *Infection and Seroconversion* -- flu-like illness for approximately two weeks. *Symptom-Free* -- a few months to many years. *Ea~y Symptoms* -- fevers, herpes zoster, yeast infections -- a few months to several years. *AIDS* -- opportunistic infections, neoplasia (Kaposi's sarcoma, lymphoma, cervical cancer), dementia, and other neurological symptoms -- a few months to several years.
Gonorrhea *Neisseria gonorrhoeae* (a gram-negative diplococcus bacteria)	Fluids -- contact of mucous membranes (cervix, urethra) with infected person's fluids (semen and mucus). Transmission most common with exposure through vaginal or anal sex. Casual contact considered to be safe.	Very similar to those of chlamydia for both women and men.
Chancroid *Hemophilus ducreyl* (a gram negative bacillus bacteria)	**Contact** -- touching an infected person's lesions can transmit cells containing the virus. Penetrative intercourse or even genital/genital touching is not necessary.	May be asymptomatic, but usually there are one or more ulcers on the genital skin which are broad, deep, and extremely painful.
Nongonnococcal Urethritis (NGU) *Chlamydia trachomatls,Ureaplasma urealyticum, Trichomonas vaginalis*	**Fluids** -- contact of mucous membranes (cervix, urethra) with infected person's fluids (semen and mucus). Transmission most common with exposure through vaginal or anal sex. Casual contact considered to be safe.	**Asymptomatic** -- or painful and frequent urination, possibly a white discharge.
Hepatitis B (HBV) *Hepatitis B Virus*	**Fluids** -- contact of mucous membranes (cervix, urethra) with infected person's fluids (semen,	At first, usually asymptomatic. If disease progresses. symptoms common to all hepatitis diseases

	saliva, blood, and mucus). Transmission most common with exposure through vaginal or anal sex. Casual contact considered being safe. Health care workers at particular risk through knife cuts and needle sticks.	may occur.
Syphilis *Treponema pallidurn* (a spirechete)	**Fluids** and Contact. Also, 50 percent risk of transmission from mother to infant in utero.	Occurs in three stages: *Primary*- painless ulcer (chancre). *Secondary*- - rash, condylomata lata, lymph node enlargement, spotty baldness. *Late/Latent*- no clinical signs. but vascular and neurological damage may be occurring.

A. Chlamydia

1. The epidemic

2. Risk reduction and sexual behavior

B. Venereal warts

C. Gonorrhea

D. Viral hepatitis

E. Herpes

1.Description of virus, signs and symptoms, epidemiology

2. Avoiding transmission, risk reduction

3. Living with herpes - sexually

F. Syphilis

G. Less common STD's

Books Safer Sex/STD
Shttp://www.drruth.com:80/picks/books/safer.html

Sexually Transmitted Diseases
http://www.public.asu.edu/~ide4bubu/sexlinks/stds.html

III.**THE DRUG/SEX/STD CONNECTION**: non-prescription drugs: alcohol and street drugs

A. Effects on sexual interest and response

B. Effects on immune system

C. Impairment of decision-making process; resultant risk-taking

D. Drug Therapies

1. Dopamine agonists

a) Levodopa, prescribed in Parkinson's disease.

b) Bromocriptine therapy for hyperprolactinemia. Patient complaint may be situational erectile dysfunction, resembling psychogenic etiology, but resulting from pituitary tumor.

Schwartz, M.F., Bauman, J.E. & Masters, W.H. (1982). Hyperprolactinemia and sexual disorders in men. Biological Psychiatry, 17. 861-876.

c) Deprenyl (selegeline) used in Parkinson's disease, appears to correct age-related decline in sexual function, and may increase lifespan. No side effects have been reported.

Knoll, J. (1985). The facilitation of dopaminergic activity in the aged brain by deprenyl: A proposal for a strategy to improve the quality of life in senescence. Mechanisms of Ageing and Development, 30. 109.

d) Amphetamines, commonly used for suppressing appetite, appear to increase sexual desire.

e) Yohimbine, an alpha-2-adrenergic receptor blocker, increases blood flow, is prescribed (probably widely) for erectile dysfunction. Side effects include changes in blood pressure, which may be risky for the aging males for whom it is prescribed.

Angrist, B.M. & Gershon, S. (1976). Clinical effects of amphetamine and L-dopa on sexuality and aggression. Comprehensive Psychiatry, 17. 715-722.

f) Nitroglycerine, in oral or transdermal (paste,) in the treatment of erectile dysfunction

Morales, A., Condra, M.S., Owen, J.E., et al., (1988). Oral and transcutaneous pharmacologic agents in the treatment of impotence. Urol. Clin. N. America, 15(1). 87.

g) Alpha-adrenergic stimulants, e.g., imipramine (Tofranil), for retrograde ejaculation, which may occur as a result of anticholinergic drugs (and after some prostate surgeries and as a consequence of diabetic neuropathy), can sometimes restore normal emission.

Goldwasser, B., Madgar, I., Jonas, P., Lunenfeld, B. & Many, M. (1983). Imipramine for the treatment of sterility in patients following retroperitoneal node dissection. Andrologia, 15. 588-591.

h). Antiandrogens, used for controlling the behavior of sex offenders (chemical castration). Pedophiles are the usual candidates.

Cooper, A.J. (1986). Progestogens in the treatment of male sex offenders: A review. Canadian Journal of Psychiatry, 31(1). 73-79.

(1) Medroxyprogesterone acetate (MPA)-Depo-Provera.

(2) Cyproterone acetate (CPA)

i) Serotonergic medications are used to control compulsive sexual behavior

Coleman, E. (1991). New directions in sex therapy. Free Inquiry, 11(4). 36.

E. Mechanical devices, used by males for penetration sex

1. External management devices

a. Negative pressure/tension band devices e.g., Erec-Aid System, Vacuum Erection Device, Pos-T-Vac System

b. Tension bands, rings, used alone to entrap blood after erection is achieved

c. Silicon sheath (external splint) supports flaccid penis

2. Penile implants-devices surgically placed internally

a. Inflatable

b. Non-inflatable-semi-rigid, hinged or malleable

MacKenzie, B. & MacKenzie, E., with Christie, L. (1988). *It's not all in your head: A couple's guide to overcoming impotence*. New York: E.P. Dutton.

F. Other surgical interventions

1. Penile arterial revascularization for the management of penile vascular insufficiency

2. Penile vascular ligation for corpus spongiosum venous leakage

G. Impotence support groups (supported by prosthesis manufacturers, urologists and hospitals where implant surgery is performed)

(1987). Medical marketing: Impotence support groups - a win-win situation. Sexuality & Disability, 8(4). 235.

H. Body therapies are in wide use for teaching sensuality and how to achieve orgasm. Since the public and the media associate these methods with the profession of sex therapist, and they are a focus of controversy in clinical sexology, the body therapies are outlined here.

Theory:

1.Hands-on healing can break sexual barriers. Sexuality is a combination of mind, body and spiritual energies; imbalances and blocks in the energies create poor functional patterns. Body therapies may include light touch, deep stimulation, skeletal adjustment, chakra/aura balancing, combination therapies and spiritual energizing techniques.

2. Massage

a) Non-verbal communication and stimulation, involving both conscious and subconscious neurochemical pathways. Energies may be added with music, aromatherapy, color therapy, subliminal tapes, hypnotic tapes, TENS stimulation, mechanical vibrators, oils and hydrotherapy. Over two dozen massage systems derive from Native American, Oriental, Swedish, Esalen, reflexology and physical medicine.

b) In order to refer responsibly and with confidence, sex therapists must experience the effects of several modes of body healing.

Downing, G. (1972). T*he massage book*. New York: Random House.

Feltman, J. (1989). *Hands-on healing*. Emmaus, PA: Rodale Press. Patten, L. & Patten, T. (1988). *Biocircuits*. Tiburon, CA: H.J. Kramer.

Stubbs, K.R. (1991). *Erotic massage: The touch of love*. Berkeley, CA: Secret Garden. I. Aphrodisiacs.

McIlvenna, R.T. (1988). The pleasure quest: The search for aphrodisiacs. San Francisco: Specific Press.

Taberner, P.V. (1985). Aphrodisiacs: The science and the myth. Philadelphia: University of Pennsylvania Press.

Yates, A. & Wolman, W. (1991). Aphrodisiacs: Myth and reality. Medical Aspects of Human Sexuality, 25(12). 58-64.

J. Imprisonment and institutionalization are historically, and probably to this day, the most frequently employed methods for changing sexual behavior.

Gebhard, P.H., Gagnon, J.H., Pomeroy, W.B. & Christenson, C.V. (1965). *Sex offenders.* New York: Harper & Row.

IV. **DRUGS THAT MAY DISTURB SEXUAL FUNCTIONING**. Some people seem to be exquisitely sensitive to a particular drug effect; others remain functional regardless of dose. Since sexual dysfunction appears to be common in the general population, and ill individuals whose physiological and psychological processes are challenged by factors other than the medications use medications, it is probably not often reasonable to attribute impaired sexual functioning to a particular drug. Following is a list of pharmaceuticals that may adversely affect desire, arousal or orgasm.

A. Prescription drugs with corresponding side effects.

1. Alpha blockers (Dibenzyline)

2. Antianxiety agents

a) Alprazolam (Xanax): inhibition of orgasm; delayed or no ejaculation

b) Diazepam (Valium): decreased libido; delayed ejaculation, retarded

c) Doxepin (Sinequan): decreased libido; ejaculatory dysfunction

3. Antibiotics (may lead to yeast infections, dyspareunia)

4. Anticholinergic agents (Atropine, Banthine, Cantil, Homapin, Pro-Banthine)

5. Anticonvulsants (Dilantin)

6. Antidepressants (Anafranil, Ascendin, Aventyl, Eskalith, Eutonyl, Marplan, Nardil, Norpramin, Pamelor, Parnate)

a) Amitriptyline (Elavil): loss of libido; impotence; no ejaculation

b) Imipramine (Tofranil): decreased libido; impotence; painful delayed ejaculation; delayed orgasm in women

7. Antipsychotic agents (Mellaril, Quide, Serentil, Taractan, Trilafon)
a) Haloperidol (Haldol): impotence; painful ejaculation

b) Thioridazine (mellaril): impotence; priapism; delayed, decreased, painful, retrograde or not ejaculation; anorgasmia

8. Cardiovascular agents

a) Antiarrhythmics

(1) Disopyramide (Norpace): impotence

b) Antihypertensives (Aldomet, Apresoline, Catapres, Ismelin, Minipress,

Serpasil)

(1) Labetalol (Trandate, Normodyne): priapism; impotence; delayed or no ejaculation

c) Beta-blockers (Blocadren, Inderal, Normodyne, Timoptic)

(1) Atenolol (Tenormin): impotence

d) Cardiotonics (Lanoxin)

e) Diuretics (Aldactone, HydroDIURIL, Hygroton, Oretic)

9. Glaucoma drugs (Neptazane)

a) Acetazolamide (Diamox): loss of libido; decreased potency

10. Histamine receptor blocking agents (Zantac)

a) Cimetidine (Tagamet): decreased libido (men and women); impotence.

11. Hormonal preparations (anabolic steroids, estrogens in men, hydroxyprogesterone, progesterone)

12. Lipid-lowering agent

a) Clofibrate (Atromid-S): decreased libido; impotence

13. Nonsteroidal anti-inflammatory agents

a) Naproxen (Naprosyn): impotence; no ejaculation

B. Over-the-counter drugs (antihistamines in prolonged use)

C. Recreational drugs

1. Alcohol - has direct destructive effect on neurogenic reflex that produces erection; damage is irreversible for many. In women, causes inhibited desire, orgasmic dysfunction, and dyspareunia.

2. Spanish Fly (cantharides), toxic, has caused priapism and permanent penile damage.

3. Amyl nitrate: has caused myocardial infarction.

4. Cocaine: chronic use decreases sexual function and interest.

5. Marijuana: regular use decreases plasma testosterone levels.

6. Heroin and methadone: cause dysfunction of erection and emission in men. In women: amenorrhea, infertility, reduced sexual desire and sensation, spontaneous abortions.

Rogers, A. (1990). Drugs and disturbed sexual functioning. In C.I. Fogel & D. Lauver (Eds.). *Sexual health promotion*, Philadelphia: W.B. Saunders.

V. **PRIVATE PRACTICE DEVELOPMENT AND MANAGEMENT**

Beigel, J.K. & Earle, R.H. (1991). Successful private practice in the 1990s: A new guide for the mental health professional. New York: Brunner/Mazel.

Browning, C.H. & Browning, B.J. (1986). Private practice handbook: The tools, tactics & techniques for successful practice development, 3rd ed. Los Alamitos, CA: Duncliff's International.

Wincze, J.P. & Carey, M.P. (1991). Continued professional development and practice. In J.P. Wincze & M.P. Carey, Sexual dysfunction: A guide for assessment and treatment. New York: Guilford Press.

Chapter 3

THE SOCIOLOGICAL PERSPECTIVE

General references

Gagnon, J.H. (1978). *Human sexualities*. Glenview, IA: Scott, Foresman.

Gagnon, J.H. and Simon, W. (1973). *Sexual conduct: The social sources of human sexuality*. Chicago: Aldine.

Irvine, J.M. (1990). *Disorders of desire: Sex and gender in modern American sexology*. Philadelphia: Temple University Press. [Historical account, sociological analysis of sexology's unexamined gender assumptions; focus on gender differences of power and privilege.]

McKinney, K. and Sprecher, S. (Eds.). (1989). *Human sexuality; The societal and interpersonal context*. Norwood, NJ: Ablex.

I. SOCIOCULTURAL FACTORS THAT AFFECT SEXUAL EXPERIENCE AND EXPRESSION.

A. Sex is a function rooted in biological nature.

B. However, its experience and expression is largely determined by sociocultural and social psychological factors.

C. Principal sociocultural factors:

1. Culture determines the meanings of experience.
2. Socioeconomic and social class-linked factors.
3. Family structure and teachings.
4. Religious and other moral and moralistic teachings.

D. Culturally determined meanings of experience.

Petras, J.W. (1978). *The social meaning of human sexuality*, (2nd ed.). Boston: Allyn & Bacon.

1. The culture in which an individual was raised and/or currently lives largely determines:

a) How sexuality is experienced.

b) What the experience means.

c) What causes sexual desire and what does not.

2. Cultural influences also affect:

a) What is considered sexual and what is not.

b) The purpose of sexual activity (for enjoyment, for status and power, for procreation, etc.)

c) The respective sexual roles of women and men.

d) Norms with respect to homosexual behaviors and identities.

e) Norms with respect to participation in nonmarital, extramarital, and postmarital sexual behavior.

f) Norms and expectations regarding sexual behaviors at each stage of the life cycle.

g) Sexual positions, duration and sites of sexual contacts.

h) Sex and affection; sex and violence - including harassment and protections.

i) The ways in which feelings and thoughts may and may not be communicated.

j) Jealousy.

E. Socioeconomic and social class-linked factors.

1. Individuals raised or living in poverty are more likely to suffer both physical and emotional deprivations, resulting in less variety, scope and satisfaction from sexual activities than experienced by those in other social classes.

2. Lack of education is associated with stereotyped sex roles.

3. Greatest variety, scope and dedication to sexual experience has been observed among the most affluent, the politically powerful and among artists.

F. Family structure and teachings.

1. Sexual values and teachings may reflect or be in conflict with the culture's stated values.

2. The family is a site for abusive sexual behavior as well as for affection and the development of a sense of sexual identity and security.

3. Couples who have learned different sexual lessons in their respective families may experience conflicts in their sexual expression.

G. Religious affiliations

1. In combination with social class factors, religious teachings range from the view that sexual pleasure is valuable experience in its own right to the belief that sexual desires and behaviors are signs of wickedness.

2. Religious influences experienced early in life may continue to influence sexual behaviors throughout life, even though the individual's beliefs have changed.

Kinsey, A.C., Pomeroy, W.B. and Martin, C. (1948). *Sexual behavior in the human male*. Philadelphia: Saunders.

Kinsey, A.C., Pomeroy, W.B., Martin, C. and Gebhard, P. (1953). *Sexual behavior in the human female*. Philadelphia: Saunders.

II. **SEXUALITY OVER THE LIFE SPAN**. Research indicates that sexuality begins prenatally and continues throughout the lifespan of all individuals. Overviews can be found in a number of college level textbooks.

Carrera, M. (1981). Sex -The acts, the facts and your feelings. New York: Crown.

Denney, N.C. and Quadagno, D. (1988). Human Sexuality. St. Louis: Times Mirror Mosby.

Crooks, R. and Baur, K. (1993). Our sexuality. Redwood City, CA: Benjamin/Cummings.

A. Childhood sexuality

Calderone, M. and Rameyk, J. (1982). Talking with your child about sex. New York: Random House.

Constantine, L.L. and Martinson, F.M. (1981). Children and Sex: New findings, new perspectives. Boston: Little, Brown.

Krivacska, J. (1993). Designing child sexual abuse prevention programs. Springfield, IL: Charles C. Thomas.

Martinson, F. (1994). The sexual life of children.

Westport, CT: Bergin & Garvey.

Martinson, F.M. (1973). Infant & child sexuality: A sociological perspective. St. Peter, MN: The Book Mark.

Moll, A. (1913). The sexual life of the child. New York: Macmillan.

Reiss, I. (1986). Journey into sexuality: an exploratory voyage. Englewood Cliffs, N.J.: Prentice-Hall.

B. Adolescent sexuality

1. Adolescent sexual behaviors

Byrne, D. and Fisher, A. (1983). *Adolescent sex and contraception*. Hillsdale, N.J.: Erlbaum.

Money, J., Perry, M.E. and Musaph, H. (1991). *Handbook of Sexology, Vol. 7: Childhood and adolescent sexology*. Elsevier Science, Inc.

Technical Bulletin #145 (1990). *The adolescent obstetric-gynecological patient*. Washington, D.C.: The American College of Obstetricians and Gynecologists.

O'Connor, M. (1992). "Psychotherapy with gay and lesbian adolescents" in Dworkin, D. and Guiterrez, M. *Counseling gay men and lesbians*. Alexandria, Va.: Association for Counseling and Development.

Gordon, S., Scales, P. and Everly, K. (1978). *The sexual adolescent*. Belmont, CA: Deuxbury.

2. Teenage pregnancy

Zelnick, M., Kantner, J. and Ford, K. (1981). *Sex and pregnancy in adolescence*. Beverly Hills, CA: Sage.

Felsman, D., Brannigan, G. and Yellin, P. (1987). Control theory in dealing with adolescent sexuality and pregnancy. Journal of Sex Education and Therapy, 13. 15-16.

Committee on Adolescent Health Care. (1991). *Safety of oral contraceptives for teenagers*. Washington, D.C.: American College of Obstetricians and Gynecologists.

C. Young and middle adult sexuality

1. Single person. Single individuals practice the same variety of sexual practices as married couples. The only difference is that all single people are unmarried whether never married, widowed or divorced.

2. Married people

3. Alternative forms of marriage and family life.

a) Cooperative and family clusters are formed when several couples pool resources and may include child rearing, sharing material goods and a sharing of intimate family secrets.

Stoller, F. (1970). The intimate network of families as a new structure, in Herbert Otto, *The family in search of a future*. New York: Appleton Century Crafts.

b) Intimate Friendship. A usual friendship in which sexual relations are part of the friendship that contains emotional intimacy. It challenges the exclusivity of the sexual bond between spouses who know about the intimate friendship.

Ramey, J. (1975). Intimate groups and networks. Family Coordinator 24. 515-530.

4. Extramarital relationships

Fisher, H.E. (1982). *The sex contract*. New York: Quill.

5. Effects of parenthood on sexuality.

Peck, E. and Granzig, W. (1978). *The parent test*. New York: Putnam & Sons.

D. Late adulthood. Many of the supposed sexual problems are really negative stereotypes or myths regarding people over sixty.

Rienzo, B. (1985). The impact of aging on human sexuality, I. School Health, 55. 66-68.

Brecher, E. (1984). *Love, sex and aging: A consumer union report*. Boston: Little, Brown & Co.

Weeks, G. and Hof, L. (1987). *Integrating sex and marital therapy*. A clinical guide. New York: Brunner/Mazel.

Blumstein, P. and Schwartz, P. (1983). *American couples*. New York: William Morrow & Co.

Lee, J. (1973). *The colors of love: An exploration of the ways of loving*. Ontario, Canada: New Press.

E. Gender perspectives

1. Sex and gender identity.

2. Gender role socialization

3. Physiology and psychology of gender differences.

Money, J. (1988). *Gay, straight and in between*. New York: Oxford University Press.

Money, J. and Erhardt, A. (1972). *Man and woman, boy and girl*. Baltimore: Johns Hopkins University Press.

USC Gender Studies
http://www-lib.usc.edu/Info/Ref/Guides/gender_bib.html#dictsex

F. Love and limerence

1. Development of a loving relationship.

2. Infatuation.

3.Gender differences about love.

4. Lust and obsessive love.

Fromm, E. (1956). *The art of loving*. New York: Harper & Row.

Garrity, J. (1977). *Total loving*. New York: Simon and Schuster.

Lasswell, M. and Lobseng, N. (1989). *Styles of loving*. New York: Ballantine/Del Rey/Fawcett.

Leibowitz, M. (1983). *The chemistry of love*. Boston: Brown & Co.

Tennov, D. (1979). *Love and limerence: The experience of being in love*. New York: Stein & Day.

G. Intimacy and communication skills.

Hendricks, G. and Hendricks, K. (1985). *Centering and the art of intimacy*. New York: Prentice Hall Press.

Tannen, D. (1990). *You just don't understand: Women and men in conversation*. New York: William Morrow & Co.

1. Interpersonal intimacy relationships.

2. Partner communication in a non-sexual context.

3. Non-communications.

Knopf, J. and Seiler, M. (1990). *Inhibited sexual desire*. New York: William Morrow & Co.

Scarf, M. (1987). *Intimate partners*. New York: Random House.

Covington, S. (1991). *Awakening your sexuality*. San Francisco: Harper & Row.

Lerner, H. (1989). *The dance of intimacy*. New York: Harper and Row.

H. Sexual fantasy

1. Functions.

2. Content

3. Gender differences

Friday, N. (1983). *My secret garden*. New York: Pocket Books.

III. **RACE AND ETHNICITY**

A. Myths and stereotypes abound about the ways in which racial and ethnic minorities do and do not behave similarly to the predominant whites, but comparatively little research has been done.

Belcastro, P.A. (1985). Sexual behavior differences between black and white students. The Journal of Sex Research, 21. 56-67.

Staples, R.T. (1973). *The Black Woman in America: Sex, Marriage, and the Family*. Chicago: Nelson-Hall.

Weinberg, M.S. (1988). Black sexuality: A test of two theories. Journal of Sex Therapy, 25. 197-218.

B. Sexual norms and mores are a major part of the self-identification of virtually all ethnic and racial groups in our society.

IV. **THE SOCIAL SCRIPT MODEL OF SEXUAL EXPRESSION**

A. Sexual attitudes and behaviors may be viewed as the result of an interaction between an individual's basic biological inheritance and the individual's internalizing of a complex of social scripts.

B. Social script components:

1. With whom one acts sexually.

2. What one does sexually.

3. When sexual experiences occur.

4. Where sexual experiences occur.

5. Why and how the experiences are explained, viewed, justified, rewarded or punished.

Money, J. (1993). Lovemaps: Clinical concepts of sexual/erotic health & pathology, paraphilia, & gender transposition in childhood, adolescence and maturity. New York: Prometheus.

Strong, B. and deVault, C. (1988). Understanding our sexuality. St. Paul: West Publishing.

V. **FEMINIST PERSPECTIVES**

A. Liberal feminism views blocks to true sexual equality as blocks to human fulfillment that must be challenged and overcome.

B. Radical feminism views sexual codes and heterosexism as a means by which male-dominated society expresses and perpetuates power over women.

C. Both challenge male-dominant definitions and norms of sexual behavior and expression.

Tiefer, L. (1988). A feminist perspective on sexology and sexuality. In M.M. Gergen, (Ed.). *Feminist thought and the structure of knowledge*. New York: New York University Press. 16-26.

Vance, C.A. & Pollis, C.S. (Eds.). (1990). Special issues, Parts 1 and 2: Feminist perspectives on sexuality. Journal of Sex Research, 27, (1 & 3).

Feminist References
http://www.cis.ohio-state.edu/hypertext/faq/usenet/feminism/refs1/faq.html

Patriarchy, Sexual Identity and the Sexual Revolution
http://yarra.vicnet.net.au/~wise/Les4.htm

Chapter 4

PATTERNS OF SEXUAL BEHAVIOR

I. INTRODUCTION

The organization of this chapter generally follows Kinsey's lead in discussing sexual behaviors in terms of "sources of sexual outlet." Further, it reviews human sexual behaviors as observed by the zoologist, without much concern for psychological or sociological meanings. In seeking the answer to "What do people do sexually?" we may find that sexology has not advanced much since the studies of Alfred Kinsey in the 1940's and 50's..

Most authorities agree that sexual behavior is more than coitus, but exactly how much more is difficult to discern. A physiological definition based on tumescence of sex organs or orgasm is one approach to the study of human sexuality. An examination of human behavior indicates that many objects and activities have sexual significance. Viewing human sexuality in this context reveals that the area is so global that it cannot be quantified for comparison and analysis. In order to proceed with the work of quantification of human sexual behavior, Kinsey, Pomeroy and Martin at Indiana University found it necessary to arbitrarily establish the function of orgasm as the unit of behavioral measurement.

A criticism to this approach is that it favors a mechanical definition of human sexuality. Unfortunately, we have no other alternative. If we are to discuss what people do, then a unit of measurement is necessary. Even after limiting our definition of human sexuality, we can still say very little in quantitative terms about how people actually live their sex lives. According to Kinsey, there are six general ways in which people can achieve orgasms. But how often do they experience each, who prefers which, and how does it all add up, we really do not know.

Almost everyone seems to have known all along that people actually behave quite differently from the ways in which they are assumed to behave.

Sexual Outlets: A Continuum of Practice:

The six main methods of obtaining orgasm, according to Kinsey, are masturbation, nocturnal sex dreams, heterosexual petting, coitus, homosexual relations and contacts with animals. Other activities such as voyeurism, sadism, masochism and fetishism are excluded as means for achieving orgasm. They may, however, accompany any of the main six. In fact it is possible for a very creative person to combine all of the above in one particular sexual encounter. While we can discuss sexual behavior in general, we cannot generalize to the individual nor can we clearly establish what is "normal" sexual behavior. The best we can do in delineating what is normal is to realize that which is normal is largely determined by the society in which that activity is practiced.

What is considered "normal" in the United States might be considered "abnormal" in other societies. Research does not indicate that man has any "normal" sexual activities, sexual preferences or rituals that can be applied to all men at all times in all societies. We can classify sexual activities but we cannot apply value judgements to these sexual activities as this is really determined by the

society in which the activity takes place and secondly, by the individual, or the individuals, involved in the sexual activities.

It's not a joke to say that common definition of sexual abnormalities has, even in the recent past, been: "any behavior that **I do not do** is considered abnormal, sexually repulsive and should be repressed."

Criteria For Evaluating Sexual Behaviors:

Of all varieties of human behavior, sex is the most controversial, conflict ridden and subject to contradictory judgment. Accepting this as a given, assessments of behavior, sexual or otherwise, are generally made according to four criteria:

1. The statistical norm. How common is the behavior?
2. The medical norm. Is the behavior healthy?
3. The ethical norm. Is the behavior moral?
4. The legal norm. Is the behavior legitimate?

It would be helpful if the four criteria listed were mutually reinforcing, but that is not always true. Something may be statistically common, medically healthy, morally sound and illegal. Thus, the legality of a particular sexual activity is not always dependent upon any of the other three criteria. The application of such value judgments of sexual behavior in a heterogeneous pluralistic society has resulted in much confusion. The meaning of a statistical norm has often been distorted. Medical judgment has often lacked scientific support. Morality has been confused with tradition. Statutes and ordinances have frozen many dubious factual claims and moral conclusions into law. Thus making a common behavior that is healthy but perhaps ethically unacceptable to some, illegal for all.

Not infrequently an original determination that a particular sex act is unhealthy or uncommon turns out to be incorrect and no longer applicable, but the moral and legal judgments based on it persist. In order to correct the misapplication of the four criteria listed above, a model law was proposed by the American Bar Association that provided for no legal restraints against any sexual activity engaged in by consenting adults in private. In 1963, the State of Illinois was the first state in which this model law was passed. Since that time, only twenty-five other states have passed a variation or modification of this sexual freedom act. Many state legislatures have been reluctant to pass the model sexual behavior act simply because they felt that this would lead to an increase in immorality, perversion and other sexual activities which they felt were disgusting and lewd.

When Illinois passed its sexual behavior act in 1963, one of the greatest fears was that, by legitimizing homosexual activity between consenting adults in private, Illinois would become a magnet for homosexuals throughout the United States and that the State of Illinois would be swamped with homosexuals who would move there to take advantage of the new law on sexual activities. This statistically, has proven to be incorrect. There neither was a sudden upsurge nor an increase in homosexual activity in the State of Illinois.

The medical norm regarding homosexuality has been changed by a vote of the American Psychiatric Association that removed homosexual behavior from its inclusion as a mental illness. In Diagnostic and Statistical Manual III (1980) it referred to: " Ego-dystonic homosexuality: if a sustained pattern of homosexual arousal persistently causes distress, and the patient wishes to acquire or increase heterosexual arousal, a diagnosis is made and treatment warranted." In DSM III-R (1983) this was

changed to: " This category has been eliminated for several reasons. It suggested to some that homosexuality itself was considered a disorder. In the United States almost all people who are homosexual first go through a phase in which their homosexuality is ego-dystonic. Furthermore, the diagnosis of Ego-dystonic homosexuality has rarely been used clinically and there have been only a few articles in the scientific literature that use the concept. Finally, the treatment programs that attempt to help bisexual men become heterosexual have not used this diagnosis. In DSM III-R, an example of Sexual Disorder NOS are cases that in DSM III would have met the criteria for Ego-dystonic Homosexuality." And finally in DSM IV (1994) this category was completely eliminated from the DSM. In other words, homosexuality today is not considered a mental illness in the view of health care and sexological professionals who set the rules.

General references

Gebhard, P.H. & Johnson, A.B. (1979). T*he Kinsey data: Marginal tabulation of the 1938-1963 interviews conducted by the Institute for Sex Research*. Philadelphia: W.B. Saunders.

Hite, S. (1978). *The Hite report*. New York: McMillan.

Janus, S. & Janus, C. (1993). *The Janus report on sexual behavior.* New York: Wiley.

Kinsey, A.C., Pomeroy, W.B. & Martin, C.E. (1948). *Sexual behavior in the human male.* Philadelphia: W.B. Saunders.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E. & Gebhard, P.H. (1953). *Sexual behavior in the human female*. Philadelphia: W. B. Saunders.

Michael, R., Gagnon, J., Laumann, E. & Kolata, G. (1994). *Sex in America.* London: Little, Brown.

II. **DEFINITIONS OF SEXUAL OUTLETS**

An analysis of the data collected by Kinsey et al. of the Institute for Sex Research at Indiana University reveals that six sexual outlets account for practically all orgasms experienced by men and women.

A. **Masturbation**: Self-stimulation for sexual arousal and discharge. It usually involves manipulation of the genitals, but may also be achieved through breast stimulation, rhythmic muscular contractions and other means. It may also involve the use of mechanical or non-mechanical devices in addition to one's own body.

De Martino, M.F. (Ed.). (1979). *Human autoerotic practices: Studies in masturbation*. New York: Human Sciences Press.

Dodson, B. (1987). *Sex for one: The joy of self loving*. New York: Harmony.

Hite, S. (1981). *The Hite report on male sexuality.* New York: Ballantine Books.

Reinisch, J., Beasley, R. & Kent, D. (1990). *The Kinsey Institute new report on sex.* New York: St. Martin's Press.

http://www.yahoo.com/society_and_culture/sexuality/sexology/

1. Solitary sexual self-stimulation.

Blank, J. (Ed.), Cottrell, H.L. & Corinne, T. (1974). *I am my lover*. Burlingame, CA: Down There Press.

Litten, H. (1992). *The joy of solo sex.* Mobile, AL: Factor Press.

Marcus, I.M. & Francis, J.J. (1975). *Masturbation from infancy to senescence*. New York: International Universities Press.

Morin, J. & Blank, J. (Ed.). (1980). *Men loving themselves: Images of male sexuality*. Burlingame, CA: Down There Press.

2. Sexual self-stimulation in social settings

a) Telephone sex

(1) The phone has become a sex toy in recent years, used by friends, lovers and casual acquaintances for dialogue that heightens pleasure in masturbation.

(2) Commercial sextalk phone lines have quickly become a popular, widely used way to enjoy sexual experience safely. Some phone numbers bring access to taped erotic recordings; some are answered live, are usually paid for with credit cards, and are limited to adults over 18 years of age.

Bedtime Sex Stories: (900) 344-5556

Boys Will Be Girls: (800) 765-8788

Chicks With Dicks: (800) 944-8887

Custom Phone Sex: (800) 205-6300

Lesbian Leather: (800) 495-7710

Dominant Chat Line: (800) 975-1661 or (900) 666-9994

Gay Cruising: (809) 446-9100

Gay Chat Line: (900) 745-2075 or (900) 745-1040

Group Orgy: (900) 745-2057 or (900) 745-1030

Gay Sex Samples: (800) 714-4865 or (800) 294-2625

Hot Gay Dateline (900) 745-1756

Kinky Bizarre Fetishes: (800) 285-5465

Kinky Leather Babies: (800) 511-2428 or (800) 588-2180

Live Bisexual Connections: (800) 766-2469

Sex by Phone: (809) 563-0595

Sex Crazed Tramps (809) 537-0693

3 Girls & You (800) 598-4786

3SUM: (800) 568-3786

Two Women: (800) 748-4420

Uncensored Fantasies: (800) 354-4277

(3) Cyber Sex

Action Online http://www.online18.com/hole

Anal Cybersex
http://www.ab-cybersex.com/anal_experience/default.html

Bondage/S&M Sex http://xsource.com/forum/faq.html

Club Voice-MALE
http://www.movo.com

CybersexCity
http:www.magma.cal~way45455/cybersex/

Cyber-Sleaze

http://www.freelooks.com/flesh

Gay Cybersex
http:www.mesohorny.com/

Lesbian
http://huizen.ddds.nl/~klaver/qc/qllesbian.html

Lesbian
http://www.eroticdesires.com/1freepixindex.html

Links
Http://www.euronet.nl/users/badboy/sen.html

Live Cybersex
http://www.ics1.com/cybersex/live.html
Online Access
http://www.twogirlsex.com/butt

Sexiest Website
http://www.online18.com/sexy

b) Correspondence sex

c) In dyadic relations-parallel self-stimulation

d) Parties

(1) Male masturbatory parties

(2)Female "jill-offs" in San Francisco, California

e) Commercial facilities-adult bookstores, bathhouses

B. **Sex dreams**: Also called nocturnal emissions and are sometimes commonly called "wet dreams." They may occur during daytime sleep as well as night sleep. The older and more common term "nocturnal emissions" is appropriately applied only to males, as women do not ejaculate even though many reach orgasm during such dreams.

Delaney, G. (1994). *Sexual dreams: Why we have them, what they mean.* New York: Fawcett Columbine.

C. **Heterosexual Petting**: Includes any physical contact between members of the opposite sexes undertaken for the purpose of sexual arousal, but not involving actual penetration of the vagina by the penis. Accidental contacts, even though sexually stimulating, do not count. In the Kinsey study only petting that led to orgasm was counted.

Brauer, A. & Brauer, D. (1990). *The ESO ecstasy program.* New York: Warner Books.

Castleman, M. (1980). *Sexual solutions.* New York: Simon & Schuster.

Comfort, A. & Comfort, J. (1974). *The joy of sex: A gourmet guide to love making*. New York: Simon & Schuster.

Hurwood, B. J. (Ed.). (1975). *Joys of oral sex*. New York: Carlyle Communications

Kitzenger, S. (1985). *Woman's experience of sex: The facts and feelings of female sexuality at every stage of life.* New York: Penguin.

Masters, W., Johnson, V. & Kolodny, R. (1994). *Heterosexuality.* New York: Harper Collins.

Meshorer, M. & Meshorer, J. (1986). *Ultimate pleasure: The secrets of easily orgasmic women.* New York: St. Martin's Press.

Paget, L. (1999). *How to be a great lover*. New York: Broadway Books.

Whipple, B. & Ogden, G. (1989). Safe encounters: How women can say yes to pleasure and no to unsafe sex. New York: Barber Hill.

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1. Kissing lips.
2. Deep Kissing (French or soul).
3. Manual breast stimulation.

4. Oral breast stimulation.
5. Manual contact with female genitalia.
6. Oral contact with female genitalia (cunnilingus).
7. Manual contact with male genitalia.
8. Oral contact with male genitalia (fellatio).
9. Genital apposition.
10. Anal intercourse.

Morin, J. (1981). *Anal pleasure and health.* Burlingame, CA: Down There Press.

D. **Coitus**: Heterosexual intercourse involving vaginal penetration by the penis. In practice, it is seldom isolated but rather comes as a culmination of petting or foreplay. When foreplay precedes coitus, it is considered part of the latter act rather than as petting, although specific activities involved -- kissing, caressing and the like – are identical.

1. Premarital.
2. Marital.
3. Extramarital

Reibstein, J. & Richards, M. (1993). *Sexual Arrangements: Marriage and the temptation of infidelity.* New York: Charles Scribner's Sons.

E. **Homosexual contacts**: Physical activity between members of the same sex for the purpose of erotic arousal and discharge. Much of the homosexual activity consists of petting, though the term is not usually used in this context. Homosexual relations may also involve anal intercourse and oral genital contacts. Men and women also perform these acts together, of course, so the acts cannot be considered homosexual by definition. What makes an act homosexual is not its nature but the fact that its partners belong to the same sex. For our purposes, homosexual activity is only one form of sexual outlet. It is not to be considered pathological or medically unhealthy. While there may be a personal bias against homosexuals and homosexual outlets, in dealing with patients who practice homosexual behavior, it must be kept in mind that homosexuality is now considered just a sexual outlet, period.

A. Female/female sexual behavior

Loulan, J. (1984). *Lesbian sex*. San Francisco: Spinsters Ink.

Martin, D. & Lyon, P. (1983). *Lesbian/woman.* updated ed. New York: Bantam.

B. Male/male sexual patterns

Hawkins, R. (1992). "Therapy with the male couple." In S. Dworkin and K. Gutierre, *Counseling gay men and lesbians.* Alexandria, VA: AACD.

C. The homosexual/heterosexual continuum

Haerbele, E.J. & Gindorf, R. (1998). *Bisexualities.* New York: The Continuum Publishing Company.

Klein, F. (1979). *The bisexual option*. New York: Arbor House.

John Money; *Gay Straight and In Between*
http://www.oup-usa.org/gcdocs/gc_0195054075.html

V.**GAY AND LESBIAN SEXUAL BEHAVIOR**

A. General Understanding and Treatment of:

1. Gay and lesbian presenters

2. Bisexual patterns

Barret, R. & Robinson, B. (1990). *Gay fathers.* Lexington, MA: Lexington Books.

Buxton, A. (1991). *The other side of the closet.* Santa Monica, CA: IBS Press, Inc.

Gochros, J. (1989). *When husbands come out of the closet.* Binghamton, NY: Harrington Press.

Klein, F. (1993). *The bisexual option.* Binghamton, NY: Harrington Park Press.

3. Effects of coming out upon the straight spouse.
    a) Ethical considerations of coming out to family friends and colleagues.

4. Research on etiology and percentages in populations.

5. Historical, cultural and religious views.

6. Reparative therapy

Chapter 5

CLINICAL SEXOLOGY: COUNSELING

I. CLINICAL SEXOLOGY

A.Distinction between sexuality counseling and sex therapy

1.Sexuality counselors see the client as functioning reasonably well. They interview, supply information about sexuality and community resources, advise, and sometimes practice some form of therapy. Duration of the therapeutic relationship is usually brief. The usual counseling process pattern:

a)Clarification of presenting problem.

b)Shared efforts at problem solution.

c)Decision making about alternatives for problem solving.

d)Referral may be likely.

2.Sex therapists usually anticipate longer-lasting processes and major changes in client emotional and physiological functioning. However, studies have found that most therapy clients have success with brief therapy. The usual therapy process pattern:

a)Diagnosis.

b)Treatment plan.

c)Cognitive-behavioral and other interventions.

General references

Annon, J.S. (1976). The behavioral treatment of sexual problems, Volume 1: Brief therapy (rev. ed.), Volume 2: Intensive therapy. New York: Harper and Row.

Kaplan, H.S. (1974). The new sex therapy. New York: Brunner/Mazel.

Masters, W. H. & Johnson, V. E. (1980). Human sexual inadequacy. New York: Bantam Books.

Moses, E. & Hawkins, Jr., R.O. (1982). Counseling

lesbian women and gay men: A life-issues approach. St. Louis, MO: C. V. Mosby.

Munjack, D.J. & Oziel, L.J. (1980). Sexual m edecine and counseling in office practice: A comprehensive treatment guide. Boston: Little, Brown.

(1973). The professional training and preparation of sex counselors and sex therapists. Washington, DC: American Association of Sex Educators, Counselors, and Therapists.

Dr. Ruth
http://www.drruth.com:80/askruth/

3.Work settings:

a) Those of sexuality counseling are diverse, determined by the special populations addressed.

b) Those of sex therapists are usually private office or teaching hospital.

B.Rationale for the professional identity of sexuality counselor. A counselor is defined by:

1. Job title.

2. Professional identity.

3. Sometimes by certification and/or licensing.

Messina, J.J. (1985). The National Academy of Certified Mental Health Counselors: Creating a new professional identity. Journal of Counseling and Development, 63. 607-608.

II. **SPECIAL POPULATIONS AND PROBLEMS ADDRESSED BY SEXUALITY COUNSELORS**

Johnson, W.R. & Kempton, W. (1981). *Sex education and counseling of special groups*. Springfield, IL: Charles C. Thomas.

A. Incest and childhood sexual abuses.

Herman, J. & Hirschman, J. (1981). *Father-daughter incest*. Boston: Harvard University Press.

James, B. & Nasjleti, M. (1983). *Treating sexually abused children and their families*. Palo Alto, CA: Consulting Psychologists Press.

Quina, K. & Carlson, N. (1989). *Rape, incest and sexual harassment.* New York: Praeger.

Yates, A. (1978). *Sex without shame: Encouraging the child's healthy sexual development*. New York: William Morrow.

B.Counseling adolescents (e.g., relationships, pregnancy prevention, sex functioning). Though the act of counseling must be as old as speech, the vocational identity of counseling became established with the development of vocational and general school counseling of adolescents.

Gordon, S., Scales. P., & Everly, K. (1979). *The sexual adolescent: Communicating with teenagers about sex*, (2nd ed.). Belmont, CA: Duxbury Press.

Sarrell, L. & Sarrell, P. M. (1979). *Sexual development & sex therapies in late adolescence*. Boston: Little, Brown.

Spain, J. (1987). *Sexual, contraceptive, and pregnancy choices: Counseling adolescents*. New York: Gardner Press.

C. Counseling the aging.

Breecher, E. (1984). *Love, sex and aging.* Boston: Little, Brown.

Wharton, G. (1981). *Sexuality and aging.* Metuchen, N.J.: Scarecrow Press.

D.Counseling people with developmental disabilities (e.g., mental retardation, autism, cerebral palsy, meningomyelocele).

de la Cruz, F. F. & Laveck, G. D. (Eds.). (1973). *Human sexuality and the mentally retarded*. New York: Brunner/Mazel.

Shea, V. (1990). Developmental disability and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders. 569-577.

E.Counseling persons with physical disabilities.

Bullard, D.G. & Knight, S.E. (Eds.). (1981). *Sexuality and disability: Personal perspectives*. St. Louis: C.V. Mosby.

Choices: In sexuality with physical disability. 16 mm & video. Mercury Productions, New York.

Neistadt, M.E. & Freda, M. (1987). *Choices: A guide to sex counseling with physically disabled adults*. Malabar, FL: Robert E. Krieger.

Disabilities, Illnesses, and Sex
http://www.public.asu.edu/~ide4bubu/sexlinks/disabil.html

1.Spinal cord injuries.

Leyson, J.F.J. (Ed.). (1991). *Sexual rehabilitation of the spinal-cord-injured patient*. Totowa, NJ: Humana Press.

Mooney T. (1975). *Sexual options for paraplegics and quadriplegics*. Boston: Little, Brown.

Rubin, B. J. (1980). *The sensuous wheeler: Sexual adjustment for the spinal cord injured*. San Francisco: MultiMedia Resource Center.

2.Counseling the hearing-impaired.

Fitz-Gerald, D. & Fitz-Gerald, M. (1978). Sexual implications of deafness. Sexuality & Disability, 1, 57-69.

3.Counseling the visually impaired.

Straw, T. (1981). Visual impairment. In D. G. Bullard & S.E. Knight, *Sexuality and physical disability: Personal perspectives*. St. Louis: C.V. Mosby. 36-39.

F.HIV/AIDS related problems.

Barret, R.L. (1989) Counseling gay men with AIDS: Human dimensions. Journal of Counseling and

Development, 67. 573-575.

1.Persons with HIV/AIDS.

Male couple facing AIDS, video. (1988). San Diego, CA: Mariposa Education & Research Foundation.

2.Healthy persons with fear of AIDS.

Bruhn, J.G. (1989). Counseling persons with a fear of AIDS. Journal of Counseling and Development, 67. 455-457.

3.Families of persons with AIDS.

Bradley, L.J. & Ostrovsky, M.A. (1989). The AIDS family: An emerging issue. Counseling and Human Development, 22. 1-12.

4.Grief counseling after loss of a partner with AIDS.

Martin, D.J. Human immunodeficiency virus and the gay community: Counseling and clinical issues. Journal of Counseling and Development, 68. 67-72.

G.Sexually transmitted diseases.

Rodway, M. and Wright, M. (Eds.). (1989). Sociopsychological aspects of sexually transmitted diseases. Monograph, Journal of Social Work & Human Sexuality, 6(2).

H.Counseling gay males, lesbians, and bisexuals.

Nichols, M. (1989). Sex therapy with lesbians, gay men, and bisexuals. In S.R. Leiblum & R.C. Rosen. *Principles and practice of sex therapy,* (2nd ed.). Update for the 1990s. New York: Guilford Press.

1.Adolescents.

Martin, D. Learning to hide: The socialization of the gay adolescent. Annals of the American Society of Adolescent

Psychiatry, Developmental and Clinical Studies, Vol. X.

2.Adult individuals and couples.

Clark, D. (1979). *Living gay*. Millbrae, CA: Celestial Arts.

3.Older adults and couples.

Berger, R.M. (1982). *Gay and gray: The older homosexual man*. Urbana, IL: University of Illinois.

I. Family planning.

1.Safer Sex/contraception and safe sex practices.

McIlvenna, T. (Ed.). (1987). *The complete guide to safe sex*. San Francisco: Specific Press.

Educational and Training opportunities
http://www.indiana.edu/~kinsey/edtr.html

2.Pregnancy and postpartum counseling.

Morford, M.L. & Barclay, L.K. (1984). Counseling the pregnant woman: Implications for birth outcomes. Personnel & Guidance Journal, 62(10). 619-623.

Richardson, A.C. et al. (1976). Decreasing post-partum sexual abstinence time. American Journal of Obstetrics and Gynecology, 126. 416.

3.Problems of conception.

Derwinski-Robinson, B. (1990). Infertility and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders. 291-304.

J.Abortion, adoption, and fostering counseling.

Keenan, C. (1990). Multidimensional aspects of caring for the abortion client. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders. 268-290.

K.Single again: counseling the separated, divorced, and widowed.

Atwood, J.D. (1988). Sexually single again. In E. Weinstein & E. Rosen, *Sexuality counseling: Issues & implications*. Pacific Grove, CA: Brooks/Cole. 59-80.

L.Counseling the culturally different.

Sue, D.W. & Sue, D. (1990). *Counseling the culturally different: Theory and practice*, (2nd ed.). Somerset NJ: John Wiley.

M.Adult victims of sexual violence.

Weinstein, E. & Rosen, E. (1988). Counseling victims of sexual assault. In E. Weinstein & E. Rosen (Eds.), *Sexuality counseling: Issues and implications*. Pacific Grove, CA: Brooks/Cole.

N.Adults sexually abused as children.

Friedrich, W. (1990). Psychotherapy of sexually abused children and their families. New York: Norton.

Jehu, D. (1988). Beyond sexual abuse: Therapy with women who were childhood victims. Somerset, NJ: John Wiley.

Josephson, G. S. & Fong-Beyette, M. L. (1987). Factors assisting female clients' disclosure of incest during counseling. Journal of Counseling and Development, 65. 475-478.

Lew, M. (1990). Victims no longer: Men recovering from incest and other child sexual abuse. New York: Harper & Row.

Maltz, W. (1991). The sexual healing journal. New York: Harper Collins.Prendergast, W. (1996). Sexual abuse of children and adolescents. New York: Continuum Publishing.

O.Counseling for sexual problems related to alcohol, other recreational drugs, and medications.

Covington, S. (1991). *Awakening your sexuality.* New

York: Harper Collins.

Pinhas, V. (1988). Sexuality counseling of people withalcohol problems; Sexuality counseling of people with chemical dependency. In E. Weinstein & E. Rosen, *Sexuality counseling: Issues and implications*. Pacific Grove, CA: Brooks/Cole.

Rogers, A. (1990). Drugs and disturbed sexual functioning. In C.I. Fogel & D. Lauver, *Sexual health promotion*. Philadelphia: W.B. Saunders, 485-497.

P.The sexually unusual. Non-coercive patterns: Fetishist, Sadomasochist, transvestite, transsexual; coercive patterns: pedophilia, voyeurist, exhibitionist, obscene phone calling; a treatment model for sexual aggression.

Counseling the transsexual. Baton Rouge, LA: Erickson Educational Foundation.

Dailey, D.M. (1988). *The sexually unusual: Guide to understanding and helping*. New York: Haworth Press.

Riddle, G.C. (1989). *Amputees and devotees*. New York: Irvington Publications.

III.**THEORETICAL BASIS FOR INTERVENTIONS**

A.Personality theories.

Corey, G. (1991). *Theory and practice of counseling and psychotherapy*, (4th ed.). Pacific Grove, CA: Brooks/Cole.

B.Psychotherapy orientations.

Herink, R. (1980). *The psychotherapy handbook*. New York: New American Library.

Patterson, C.H. (1969). What is counseling psychology? Journal of Counseling Psychology, 16. 23-29.

1.Cognitive-behavior therapy. Active/directive approach; first addresses the emotional disturbance secondary to sexual problems, then, the sexual problem itself.

Ellis, A. (1986). Application of rational-emotive therapy to

love problems; Wolfe, J. & Walen, S. Cognitive factors in sexual behavior. In A. Ellis & R.M. Grieger, *Handbook of rational-emotive therapy,* Vol 2. New York: Springer.

Albert Ellis Institute
http://www.irebt.org/

Books for Mental Health Professional
http://www.bmpub.com/books~1.htm

2.C1ient-centered (person-centered) therapy. Non-directive.

Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.

3.Gestalt therapy.

Passons, W.R. (1975). *Gestalt approaches in counseling*. New York: Holt, Rinehart & Winston.

4.Systems theory - family therapy.

Sager, C.J. & Kaplan H.S. (Eds.). (1972). *Progress in group and family therapy*. New York: Brunner/Mazel.

Satir, V. (1964). *Conjoint family therapy: A guide to theory and technique*. Palo Alto, CA:

von Bertalanffy, L. (1968). *General systems theory*. Science and Behavior Books. New York: Brasiller.

5.Object relations theory. A post-Freudian psychodynamic conceptualization of developmental sexuality.

Fairbairn, W.R.D. (1963). Synopsis of an object-relations theory of the personality. International Journal of Psycho-Analysis, 44. 224-225.

Scharff, D.E. (1982). *The sexual relationships: An object-relations view of sex and the family*. London: Routledge and Kegan Paul.

6.Psychoanalytic theory. Freud's legacy, along with penis-envy and the immaturity of the clitoral orgasm; analysis of transference, counter-transference, and resistance.

Nye, R. (1981). *Three psychologies: Perspectives from Freud, Skinner, and Rogers* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

7.Crisis intervention.

Everstine, D.S. & Everstine, L. (1983). *People in crisis: Strategic therapeutic intervention*. New York: Brunner/Mazel.

C.Feminist theories.

Vance, C.S. (Ed.). (1984). *Pleasure and danger: exploring female sexuality*. Boston: Routledge & Kegan Paul.

D.Men.

Farrell, W. (1993). *The myth of male power*. New York: Simon and Schuster.

IV.**COUNSELING METHOD**

A.Interviewing.

Wincze, J.P. and Carey, M.P. (1991). Assessment, 65-94. *Sexual dysfunction: A guide for assessment and treatment*. New York: Guilford.

B.Self-report questionnaires.

C.Assessment: DSM-IV diagnostic categories needed for third party payment reports and communication with health professionals. Codes are established for sexual dysfunctions, gender identity disorders, and paraphilias, all conceptualized as psychiatric disorders.

American Psychiatric Association (1994). *The diagnostic and statistical manual of mental disorders*, (4th ed. revised.). Washington, DC: American Psychiatric Association.

D.The PLISSIT logical order of interventions.

Annon, J. (1974). *The behavior treatment of sexual problems: Vol. I, Brief Therapy*. Honolulu: Enabling Systems.

1.PLISSIT (P-LI-SS-IT) is a mnemonic, derived from observation of a clinical population, which defines four sequential treatment levels and can be used in addressing a client's sexual problem.

P = giving Permission. If this doesn't solve problem-

go to: LI = giving Limited Information. If problem persists-

go to: SS = making Specific Suggestions. If problem persists-

refer to therapist for:

IT = Intensive Therapy

Annon, J. (1975). *The Behavioral treatment of sexual problems: Vol. II, Intensive therapy.* Honolulu: Enabling Systems.

V.**MODES OF COUNSELING**

A.Individual counseling.

B.Couple counseling.

Reibstein, J. & Richards, M. (1993). *Sexual arrangements.* New York: Scribners.

Renshaw, D. (1995). *Seven weeks to better sex.* New York: Random House.

C.Family counseling.

D.Group counseling.

1.Preorgasmic women's groups

E.Hypnosis.

Barham, M. (1998). Hypnotherapy and its uses and efficacy in sexual dysfunction. CliniScope; The American Academy of Clinical Sexologists Clinical Monograph, 6.

VI.**COUNSELING SETTINGS**

Barham, M. & Greene, J. (1993). *Yesterday's children.* New York: Vantage Press.

A.Schools.

B.Religious institutions (e.g., pastoral counseling).

Lovinger, R.J. (1990). *Religion and counseling: The psychological impact of religious belief.* New York: Continuum.

C.Medical clinics (e.g., family planning clinics, rehabilitation centers, hospitals).

(1984). *This is Planned Parenthood.* New York: Planned Parenthood Federation of America.

D.City Health Departments.

E.Mental health clinics.

F.Private practice (marriage and family counselors).

G.Telephone hot lines.

VII. COMPONENTS OF EDUCATION AND TRAINING FOR SEXUALITY COUNSELING

A. Interviewing skills.

B. Knowledge of sexuality issues of special populations.

C. Assessment of sexual dysfunctions and other problems.

D. Psychosexual treatment theory and methods.

E. Decision-making and problem-solving theory and skills.

F. Ethical and legal issues for client and counselor.

G. Work through own unresolved sexual guilt, negative attitudes and anxiety.

Chapter 6

CLINICAL SEXOLOGY: THERAPY

I.**INTRODUCTION**. The last few years have seen an explosion of information about sexual function and dysfunction, problems and interventions. Some of the important manuals of the seventies and eighties suddenly seem archaic.

A. Physiological assessment. Various medical specialties have produced new diagnostic and therapeutic procedures which are quickly changing the practice of sex therapy.

B. Non-dysfunction problems. Clinical sexology increasingly addresses the issues of non-coercive sexual offense, sexual orientation, and HIV/AIDS.

C. Changing psychosocial approaches. Clinical sexologists are gradually reverting to psychodynamic, family-of-origin, and family systems theories and approaches to sexuality problems.

General references

Bancroft, J. (1989). *Human sexuality and its problems,* (2nd ed.). Edinburgh: Churchill Livingstone.

Francoeur, R., Perper, T., & Scherzer, N. (1991). *A descriptive dictionary and atlas of sexology.* New York: Greenwood Press.

Hammer, D. & Copeland, P. (1994). *The science of desire.* New York: Simon & Schuster..

Kaplan, H.S. (1983). *Disorders of sexual desires.* New York: Brunner/Mazel.

Masters, W., Johnson, V, & Kolodny, R. (1994). *Heterosexuality.* New York: Harper Collins.

Wincze, J.P. & Carey, M.P. (1991). Sexual *Dysfunction: A guide for assessment and treatment*. New York: Guilford.

Sexual Disorders
http://www.priory.com/journals/sex.htm

Journal of Sex and Marital Therapy
Brunner/Mazel, Inc. Publishers
http://www.bmpub.com/jourjsmt.html

Brunner/Mazel, Inc. Publishers
(Search: Sex and Marital)
http://www.bmpub.com/_vti_bin/shtml.dll/search.htm

Sex Therapy Books
http://www.bmpub.com/fager/sext.html

II. **SEXUAL PROBLEMS.** The practicalities of professional life require that problems be identified according to the DSM-IV criteria. DSM-IV addresses sexual problems from a psychiatric perspective; diagnostic criteria are given only for problems of desire, dysfunction, gender dysphoria, and paraphilia. Though common practice, since the Masters and Johnson revolution in sex therapy, has been to identify a specific, discrete sexual response phase disorder-and focus treatment on that phase alone-the concept of separation and separate treatment of the various response phases, though satisfying in its tidy textbook clarity, may not match the realities of sexual problems. Patient, detailed inquiry into all aspects of sexual experience may reveal that multiple phase disorders resulting from multiple etiologies are the common condition.

A. DSM-IV major diagnostic categories of sexual dysfunction:

1. These dysfunctions may be further characterized as:

*a)*Primary (lifelong) or secondary (acquired)

*b)*Generalized (occurring with all partners and in all sexual situations) or situational (occurring only with certain partners or in certain situations)

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders,* (4th ed.). Washington, DC: American Psychiatric Association.

2.Problems of desire. Since the word desire has many meanings, problems arise in interpreting clients' presenting complaints that involve "desire." DSM-IV uses the word in the sense of want: "Persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity." But most sex therapists probably conceive of sexual desire in the sense of "turn-on," a synonym suggested by Apfelbaum. The concept of libido, or "drive" is now generally rejected.

Kaplan, H. S. (1979). *Disorders of sexual desire and other new concepts and techniques in sex therapy*. New York: Brunner/Mazel.

Kaplan, H. S. (1987). *Disorders of sexual desire.*. New York: Brunner/Mazel.

Knopf, J. & Seiler, M. (1990) *Inhibited sexual desire.* New York: Morrow.

a) Desire discrepancy appears to be the couple sexual problem that is most

frequently seen by sex therapists. Usually it is the partner with the lesser sexual interest who is identified as having "the problem."

(1) Nowadays the more interested partner may be referred to as "addicted" or "compulsive," especially if the individual's lifestyle is not monogamously heterosexual. Such "diagnostic" labeling, often applied to people who like casual or solo sex, seems unethical and may be considered iatrogenic.

(2) There is no DSM-IV classification for discrepancy of desire, but the condition of the less desirous partner may be labeled "Hypoactive Sexual Desire Disorder"(302.71).

Apfelbaum, B. (1989). *Beyond dysfunction syllabus*. Berkeley, CA: BSTG Seminars. 10-22.

b) Mutual sexual withdrawal refers to a range of problems including the unconsummated marriage. The couple may come to therapy because they would like to conceive.

Renshaw, D. (1989). The unconsummated marriage. Medical Aspects of Human Sexuality, 23(8). Aug.

3. Women's sex problems. The term dysfunction is used in the DSM-IV, but the word implies an individual's "pathological shortcoming," and discounts the pathology of the social context.

Barbach, L.F. (1982). *For each other: Sharing sexual intimacy*. Garden City, NY: Anchor Press/Doubleday.

Cole, E. & Rothblum, E. D. (Eds.). (1988). *Women and sex therapy*. New York: Haworth.

a) Female sexual arousal disorder (302.72). Formerly pejoratively labeled "frigidity," refers to absence of (or minimal) genital swelling, lubrication, and subjective sense of sexual excitement and pleasure during desired sexual experience.

Wincze, J.P. & Carey, M.P. (1991). Sexual dysfunction: A guide for assessment and treatment. New York: Guilford. 36-39.

b) Anorgasmia. The DSM-IV label "Inhibited female orgasm" (302.73), seems to imply that it is "normal" to have orgasms (though many do not) and that those who do not have orgasms must be psychologically inhibited. Behavioral techniques are considered helpful in 90% of cases, enabling many women to learn to masturbate to orgasm. However, most women presenting at sex clinics with anorgasmia would like coital, preferably "no hands," orgasms.

Barbach, L. (1975). *For yourself: The fulfillment of female sexuality*. New York: Signet.

Heiman, J.R. & LoPiccolo, J. (1988). *Becoming orgasmic: A sexual and personal growth program for women,* (rev. ed.). New York: Prentice Hall.

(1)Primary anorgasmia means that orgasm has never been experienced while awake, by any means.

(2) Situational anorgasmia is variously understood by sex therapists. It usually means that orgasm is not experienced at the present time with a specific partner, with or without hands.

(a) Sexual aversion (302.79). The disturbed aversive state, characterized by fear, appears to dissipate once the client can feel entitled to active dislike. Kaplan reports successful intervention by way of the pharmacological route.

Kaplan, H.S. (1987). *Sexual aversion, sexual phobias, and panic disorders*. New York: Brunner/Mazel.

c) Problems of penetration. In the past these were treated as psychological problems.

(1) Vaginismus (306.51) is an involuntary tensing of muscles at the vaginal opening, either at sexual penetration or during pelvic examination. Formerly believed to be a conditioned response, currently thought to usually result from vaginitis.

(1996). *Guidelines for women's health care.* Washington, DC: ACOG.

(2) Dyspareunia (302.76) is genital pain before, during, or after sexual intercourse. Unless resulting from lack of lubrication or from vaginismus, it is best thought of as an organic problem. Kolodny, Masters, and Johnson, (1979), list thirty-eight possible causes.

Glatt, A. et al. (1990). The prevalence of dyspareunia. Obstetrics and Gynecology(75)3 - Part One. 433-436.

Glatt, A., et al. (1992). *Pain during intercourse.* APO20. Washington, DC: ACOG.

Kolodny, R.S., Masters, W.H. & Johnson, V.E. (1979) *Textbook of sexual medicine*. Boston: Little, Brown.

4.Men's sexual problems. Almost all sex therapists try to help men liberate themselves from the demands of male sex role expectations; this can make for a brief and immediately relieving therapy.

Zilbergeld, B. (1992). *The new male sexuality*. New York: Bantam.

*a)*Erectile dysfunction, or disorder (302.72)

(1) About labeling: historically, an erection problem was called impotence ("powerlessness"), and this pejorative label is the term used by most physicians, by some

psychologists (as in Psychological Abstracts), and psychoanalysts. Masters and Johnson relabeled the problem "dysfunction," a term that most clinical sexologists use. But DSM-IV turns an erection problem into a psychiatric disorder when the problem meets its diagnostic criteria.

(2) Functional or organic? In earlier years therapists assumed that almost all erection problems were psychogenic. "Either/or" diagnoses were made. The role of psychological and emotional disturbances as causes of erectile dysfunction, is still unclear as possible contributing factors.

Fineman, K.R. & Rettinger, H.T. (1991). Development of the male function profile/impotence questionnaire. Psychological Reports (68). 1151-1175.

Wincze, J.P. & Carey, M.P. (1991). Male erectile disorder, 28-36. In J.P. Wincze & M.P. Carey, *Sexual dysfunction: A guide for assessment and treatment*. New York: Guilford Press.

(3)Non-surgical techniques

Engel, R. & Fein, R. (1990). Mentor GFS inflatable prosthesis. Urology (35)5. 405-406.

(4)Additional medical techniques[1]

ORAL MEDICATIONPROS AND CONS

Viagra (sildenafil)Can cause headaches and diarrhea. May help most with erectile dysfunction.

Spontane (apahomorphine)Studies indicate it helps in final trials by manufacturermostly mild cases - 70% in one study.

Vasomax (Phentolimane)Helped 60% - 80% of under FDA reviewthose tested. Fewer side effects then Viagra.

SUPPOSITORYPROS AND CONS

Muse (alprostadil)Can be used twice a day. approved 1997 Not recommended with pregnant partners.

INJECTION THERAPYPROS AND CONS

[1]Leland, J. (1997). A pill for impotence. Newsweek, (November 17). 65.

Caverject (alprostadil) approved 1997	Effective in over 50% of cases. May be painful and	can't be used every day.
Edex (alprostadil) approved 1997	Cheaper than Caverject and injected with a smaller	needle.
Invicorp (Vip and phentolamine) FDA submission in 1998	May be more effective than alprostadil and	doesn't cause pain.

DEVICES PROS AND CONS

Vacuum pump approved 1982	Clumsy, but has few side effects. Ejaculation may be	difficult.

SURGERY PROS AND CONS

Vascular began 1973	Effective only when problem results from a simple vascular	injury.
Penal implants began 1966	Newer implants are reliable but destroy erectile tissue.	A last resort.

b) Orgasm problems. Physicians and laypersons often refer to problems of orgasm and ejaculation as "impotence."

(1) Premature ejaculation (302.75), or "early ejaculation," is the most common male presenting complaint brought to sex therapists.

McCarthy, B.W. (1989). Cognitive-behavioral strategies and techniques in the treatment of early ejaculation. In S.R. Leiblum & R.C. Rosen, (Eds.). *Principles and practice of sex therapy, 2nd ed., Update for the 1990s.* New York: Guilford.

(2) Inhibited ejaculation, or retarded ejaculation; "partner anorgasmia." Many men who are seen clinically from highly restrictive religious backgrounds present with this concern because they are unable to resolve their lifelong depiction of women.

Apfelbaum, B. (1989). Retarded ejaculation: a much-misunderstood syndrome. In S.R. Leiblum & R.C. Rosen (Eds.). *Principles and practice of sex*

therapy, (2nd ed.). New York: Guilford.

(3) Retrograde ejaculation. Most common cause is prostate surgery. Some males report no change in orgasm sensation; others mourn loss of visible ejaculate and give up sexual experience. The latter can benefit from sex education.

*c)*Painful intercourse, or dyspareunia (302.76), "recurrent or persistent genital pain during or after intercourse" (DSM-IV). Male dyspareunia, usually associated with a urinary tract infection, is also experienced with masturbation.

Bancroft, J. (1989). *Human sexuality and its problems*, (2nd ed.). Edinburgh: Churchill Livingstone.

5. Paraphilias (mainly male)

a) The paraphilias (defined as sex problems by law or custom). Behavior modification in combination with antiandrogen drugs, such as medroxyprogesterone, have been used with some success in males with severe antisocial paraphilias Formerly called sexual deviations or perversions, paraphilic patterns such as sadomasochism, fetishism, and transvestism are enjoyed by many in an unproblematic manner. The following paraphilias includes the DSM-IV classification.

(1) Transvestic fetishism (302.3)

(2) Fetishism (302.81)

(3)Frotteurism (302.89)

(4) Pedophilia (302.2)

(5) Exhibitionism (302.4)

(6) Voyeurism (302.82)

(7) Sexual sadism (302.84)

Dailey, D.M. (Ed.). (1988). *The sexually unusual: Guide to understanding and helping.* New York: Haworth Press.

(8)Sexual masochism (302.83)

Granzig, W. (1997). Sadomasochism: A clinician's guide to terminology. Cliniscope(5). Washington, DC:AACS.

(9)Not otherwise specified (302.9)

Money, J. (1988). *Gay, straight, and in-between.* New

York: Oxford University Press.

b) Compulsive sexual behavior is characteristic of some schizophrenics, but the term is now used in reference to sexual frequency that is greater than average (or greater than the therapist's).

(1) Treatment success is reported with serotonergic medications and group therapy.

Coleman, E. (1991). New directions in sex therapy. Free inquiry, 11(4). 35-38.

(2)Frequent orgasm-seeking behavior has been termed sexual addiction, although the criteria for addiction (withdrawal symptoms and habituation) are absent. Addictionologists recommend stays at "drying out farms," followed by attendance at semi-religious confessional meetings.

Carnes, P. (1983). *Out of the shadows: Understanding sex addiction.* Minneapolis: CompCare.

c) Gender identity disorders. Individuals express the belief that they are born in the body of the wrong sex. Most are males who desire to live stereotypical female gender roles. Some desire surgical removal of genitals and genital reconstruction; they almost always require long-term counseling. Others (pre-ops) merely desire breast enlargement, buy hormones on the street, and rarely seek counseling.

Koranyi, E.K. (1980). *Transsexuality in the male: The spectrum of gender dysphoria.* Springfield, IL: Charles C. Thomas.

Schaefer, L., Wheeler, T. & Futterweit, W. (1995). Gender identity disorders (transsexualism). In G. Gabbard (Ed.), *Treatment of psychiatric disorders*, 2nd ed. Washington, DC: American Psychiatric Press.

*d)*Homosexuality. Since the 1974 removal of homosexuality from the list of mental disorders by the American Psychiatric Association, homosexuality has been defined as follows:

(1)DSM-III (1980): Ego-dystonic homosexuality.
If a sustained pattern of homosexual arousal persistently causes distress, and the patient wishes to acquire or increase heterosexual arousal, a diagnosis is made and treatment warranted.[2]

(2)DSM-III-R (1983): Ego-dystonic homosexuality.
"This category has been eliminated for several reasons.

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[2](1980). *Diagnostic and Statistic Manual of Mental Disorders,* (3rd ed.). Washington, DC: American Psychiatric Association.

> It suggested to some that homosexuality itself was considered a disorder. In the United States almost all people who are homosexual first go through a phase in which their homosexuality is ego-dystonic. Furthermore, the diagnosis of Ego-dystonic Homosexuality has rarely been used clinically and there have been only a few articles in the scientific literature that use the concept. Finally, the treatment programs that attempt to help bisexual men become heterosexual have not used this diagnosis. In DSM-II-R, an example of Sexual Disorder NOS are cases that in DSM-III would have met the criteria for Ego-dystonic Homosexuality."[3]

(3)DSM-IV (1994): category completely eliminated.[4]

III. **ETIOLOGY**

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[3](1983). *Diagnostic and Statistic Manual of Mental Disorders,* (rev'd 3rd ed.). Washington, DC: American Psychiatric Association.

[4](1994). *Diagnostic and Statistic Manual of Mental Disorders,* (4th ed.). Washington, DC: American Psychiatric Association.

A. Multiple factors in client history. Sexual problems result from a complex of factors in clients' life experience:

1. Predisposing factors (such as diabetes or childhood sexual trauma)

2. Triggering events (such as loss of a job or a lover)

3.Maintaining conditions (such as heavy drinking or domestic strife)

B. Causes of sexual problems may be determined to be:

1. Medical or biological (peripheral ischemia or hormone change)

2. Psychological (depression or anxiety)

3. Related to social context (internalized oppressive sexual script or communication failure in a marriage)

C. Complexity of causation. It is likely that in any sexual problem all three of the above causative factors are involved. Sex therapy has outgrown the simplistic diagnostic question of its past: "Is the problem medical or neurotic?"

Hawton, K. (1985). *Sex therapy: A practical guide*. Northvale, NJ: Aronson.

IV. **ASSESSMENT**

Kaplan, H. S. (1983). *The evaluation of sexual disorders: Psychological and medical aspects*. New York: Brunner/Mazel.

A. Procedure leading to diagnosis

1. Interviewing. Presenting problem and sex history

Morganstern, K.P. (1988). behavioral interviewing. In A.S. Bellack & M. Hersen (Eds.), *Behavioral assessment: A practical handbook*. (86-118). Elmsford, NY: Pergamon Press.

Pomeroy, W.B., Flax, C.C. & Wheeler, C.C. (1982). *Taking a sex history: Interviewing and coding*. New York: Free Press.

2. Using self-report questionnaires

a) SII, (LoPiccolo & Steger, 1974). The Sexual Interaction Inventory, for assessment of sexual dysfunction in heterosexual couples

b) DAS, (Spanier, 1976). The Dyadic Adjustment Scale

c) DSFI, (Derogatis & Melisaratos, 1979). Derogatis Sexual Functioning Index.

d) SOS, (Fisher, Bourne, White, & Kelley). Sexual Opinion Survey.

e) Medical history questionnaire

3. Psychophysiological assessment procedures, used mainly with men.

a) NPT-Nocturnal Penile Tumescence.

Schiavi, R. (1988). NPT in the evaluation of erectile disorders: A critical review. Journal of Sex and Marital Therapy, 14. 83-86.

b) Daytime Arousal Evaluation-direct measurement of response to erotic stimulation.

Wincze, J.P., Bansal, S., Malhotra, C.M., Balko, A., Susset, J.G., & Malamud, M.A. (1988). A comparison of nocturnal penile tumescence and penile response to erotic stimulation during waking states in comprehensively diagnosed groups of males experiencing erectile difficulties. Archives of SexualBehavior, 17. 333-348.

4. Medical evaluation. Urological or gynecological work-up.

Pinckney, C. & Pinckney, E.R. (1986). *The patient's guide to medical tests* (3rd ed.). New York: Facts on File.

B. Purposes of procedure:

1. Initially defining the problem, achieving client/therapist agreement as to the problem they will address.

2. Formulating a working hypothesis of problem's etiology

3.Identifying therapeutic goals

4. Providing feedback to the client

5. Establishing baseline functioning-from which to evaluate efficacy of treatment

V. **PSYCHOSOCIAL APPROACHES TO TREATMENT OF SEXUAL PROBLEMS**

A. Early methods

1. In the first decades of the twentieth century, sex therapists such as Bloch, Forel, and Robie were active-directive in method, following the medical model for physician-patient relationship.

Bloch, I. (1908). *The sexual life of our time*. NY: Rebman.

Robie, W.F. (1925). *The art of love*. Ithaca NY: Rational Life Press.

2. Psychoanalysis then took over the sex therapy field until about 1960. Sexual problems were viewed as symptoms of underlying personality problems stemming from unresolved childhood conflicts. Psychodynamic method, including analysis of dreams, of transference and countertransference, became non-directive, time-consuming, expensive, and rarely effective in solving sex problems.

Ferenczi, S. (1950). *Sex in psychoanalysis*. New York: Basic Books.

3. Behavior modification techniques, based on learning theory, were described by Wolpe and others in the fifties.

a) Short-term sex therapy. Behavior therapists observed that many sexual problems were quickly helped by means of conditioning techniques alone, without seeking insight into intrapsychic conflict or belief systems.

Annon, J.S. (1974). *The behavioral treatment of sexual problems,* Vols. 1 & 2. New York: Harper & Row.

b) Restructuring belief systems. In the fifties Albert Ellis found that disputing clients' irrational cognitions and teaching how these cognitions generate self-defeating emotions and behavior was more effective for a larger client population than behavior modification alone. To this day cognitive-behavior therapy underlies almost all sex therapy approaches.

B. Rational-Emotive and Cognitive-Behavior Sex Therapy.

1. In 1955 Albert Ellis founded Rational-Emotive Therapy (RET), an active-directive approach which combined cognitive, behavioral, and emotive techniques. It was quickly adopted by other therapists who added their own modifications; these variations and RET are now called cognitive-behavior therapies (CBT).

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus NJ: Citadel.

Ellis, A. (1962). *The American sexual tragedy*. Rev. ed. New York: Lyle Stuart and Grove Press.

2. High success rate with brief cognitive-behavior therapy in treating sexual

dysfunctions was reported by Masters and Johnson in 1970. Media attention was immediate and soon afterward CBT was endorsed by almost all clinical sexologists, including Annon, Barbach, Kaplan, LoPiccolo and LoPiccolo, and Zilbergeld.

3. RET theory

a. Anxiety is caused by "shoulds." In sex relations as in other aspects of living, people get disturbed by their irrational thinking about events in their lives - whether current or in the past. They mainly create their sexual problems by taking their desires for problem-free love or sex and escalating them into dogmatic demands - shoulds, musts, needs. The result is anxiety.

b. Anxiety about anxiety. When individuals say to themselves, "I must not have to experience anxiety in a sexual situation," they generate anxiety about their sexual anxiety, which usually results in dysfunction, aversion, or disturbed sexual behavior.

Ellis, A. (1958). *Sex without guilt*, Rev. ed. (1965). New York: Lyle Stuart.

Ellis, A. (1960). *The art and science of love*. Secaucus, NJ: Lyle Stuart.

4. Clinical method

a) RET goals. The Rational-Emotive sex therapist has two goals:

(1) Problem solving. To help solve the immediate sexual problem, especially by vigorously disputing the shoulds.

(2) Philosophic level. To help the client develop an effective philosophy about sex (and other aspects of living).

b) RET uses an ABC model for conceptualizing the Activating event-Belief-Consequence (emotional or behavioral) relationship and for addressing the sexual problem. For example:

(1) At 'A' (Activating event) people get together for sex.

(2) At 'C' (Consequences) they make themselves anxious and fail. They wrongly believe that poor conditions at 'A' made them fail.

(3) Actually, their belief system (B) about 'A' is the main cause of their anxiety and dysfunction. This belief 'B' is that they have to absolutely succeed and if they do not, they are rotten people.

c) RET teaches cognitive, emotive, and behavioral methods for actively

Disputing (D) irrational Beliefs (IBs) - to think, feel, and act against them.

*d)*Clients thereby arrive at 'E'- an Effective New Philosophy: "I may often fail because I am a fallible human, but failure doesn't make me an inadequate person. We can try different methods until we find sexual enjoyment, but if we never do we can still pursue a happy life."

5. Additional cognitive methods used:

a) Rational coping self-statements

b) Referencing

*c)*Proselytizing

d) Recording of sessions

*e)*Instruction and skill training

f) Bibliotherapy and audiotherapy

6. Emotive techniques used in RET:

a) Rational-emotive imagery

b) Shame-attacking exercises

*c)*Forceful coping statements

d) Rational-emotive role playing

*e)*Rational humorous songs

*f)*Unconditional therapist acceptance

7. Behavioral methods used in RET:

a) In vivo desensitization

b) Exposure and relapse prevention for phobic, obsessive- compulsive, and other disturbed clients

*c)*Self-reward and self-penalizing for behavior shaping.

Bass, B. A. & Walen, S. R. (1986). Rational-emotive treatment for the sexual problems of couples. Journal of Rational-Emotive Therapy, 4(1). 82-94.

C. Masters and Johnson model: a treatment package for sex therapy with couples which gained worldwide media coverage in the seventies. 1970 publication of Human Sexual Inadequacy,

which appeared to be a simple and clear treatment manual, was followed by creation of sex dysfunction centers in universities and hospitals nationwide.

Masters, W. & Johnson, V. (1970). *Human sexual inadequacy*. Boston: Little, Brown.

1. Clinical sexologists who believed (and claimed) that they were following the Masters and Johnson model found that their failure rates were much greater than those reported by Masters and Johnson. Masters has explained this, stating that key elements in their program were the requirements that the couple live away from home and that the clinicians may be consulted by phone at any time-they were available twenty-four hours a day for the twelve days of treatment.

2. The "sensate focus" assignment, which was used by Masters and Johnson as a diagnostic instrument (according to Apfelbaum), is generally used by other clinicians for the purpose of desensitization and resensitization. The commonly given instruction, "Just enjoy the touch" is iatrogenic because clients who are not enjoying the situation in which they are touched, but feel downright uncomfortable, can only conclude that there's something wrong with themselves-rather than with the therapy.

Apfelbaum, B. (1983). The Masters and Johnson breakthrough: Sexual arousal as a response. In *Expanding the boundaries of sex therapy*. Berkeley, CA: BSTG.

D. Post-M&J modified models

1.Sexual techniques model, incorporating videotherapy and hypnotherapy. Incorporated the "sexological examination" and many body contact exercises.

Hartman, W. E. & Fithian, M. A. (1972). *Treatment of sexual dysfunction: A bio-psycho-social approach*. Long Beach, CA: Center for Marital and Sexual Studies.

2. Hypnosis, used by practitioners for varying purposes, including relaxation with cognitive behavior therapy, regression for finding child abuse history, and Ericksonian hypnosis combined with NeuroLinguistic Programming.

Araoz, D. (1982). *Hypnosis and sex therapy*. New York: Brunner/Mazel.

Araoz, D. (1991). *Sexual joy through self hypnosis*. Glendale, CA: Westwood Publishing.

3. "Integrative" model uses psychodynamic hypotheses for diagnosis and behavioral interventions for short-term treatment. Upon failure, long-term psychoanalytic insight therapy is recommended.

Garippa, P. (1991). Multiple severe sexual dysfunctions resolved in brief [11-month] sex therapy. Journal ofSex and Marital Therapy, 17(3).

Kaplan, H. S. (1987). *The illustrated manual of sex therapy*. (2nd ed.). New York: Brunner/Mazel.

Weeks, G. & Hof, L., (Eds.). (1987). *Integrating sex and marital therapy*. New York: Brunner-Mazel.

4. Ego-analytic model, used by Berkeley Sex Therapy Group, appears to be closest to the original Masters and Johnson model. Uses homework tasks for sensitizing (helping clients become aware of how distasteful their situation and their partner's situation is) rather than for desensitizing clients. Their "counter- bypassing" approach takes a tack opposite to the "bypassing" of Kaplan and other sex-positive sexologists.

Apfelbaum, B. (1983). *Expanding the boundaries of sex therapy: The ego-analytic model*. (2nd ed.). Berkeley, CA: Berkeley Sex Therapy Group.

5. Surrogate therapy. Most surrogate/therapist teams use the sexual techniques approach of Hartman and Fithian. Dauw reports on surrogate-assisted therapy with 501 clients treated in the seventies, using bibliotherapy, audiotapes, and films. Behavior changes were achieved faster and at greater cost than in "traditional psychotherapy." This is the standard model of surrogate therapy in which the bypassing surrogate attempts to present the persona of the "caring, comfortable" partner.

Dauw, D.C. (1984). *Sex therapy innovations*. Prospect Heights, IL: Waveland Press. [Describes surrogate-assisted sex therapy.]

DeHaan, J. (1986). *Reaching intimacy: A male sex surrogate's perspective*. New York: St. Martin's Press.

Apfelbaum, B. (1984). The ego-analytic approach to individual body-work sex therapy: Five case examples. The Journal of Sex Research, 20. 44-70.

6. Group therapy

Mills, K.H. & Kilmann, P.R. (1982). Group treatment of sexual dysfunctions: A methodological review of the outcome literature. Journal of Sex and Marital Therapy, 8. 259-296.

7. Marital/family/sex therapy.

Schnarch, D.M. (1991). *Constructing the sexual crucible: An integration of sexual and marital therapy*. New York: W.W. Norton.

Weeks, G.R. & Hof, I., (Eds.). (1987). *Integrating sex and marital therapy: A clinical guide*. New York: Brunner/Mazel.

8."Post-modern" sex therapy. Combines family-of-origin, systemic, psychodynamic, and environmental reinforcement concepts with cognitive and behavioral approaches for long-term treatment.

LoPiccolo, J. (1991). Patient resistance. Contemporary Sexuality, 25(7). 3-5; Patient resistance: The waltz of growth and fear, 25(8). 3-5.

VI. **MEDICAL AND OTHER PHYSIOLOGICAL INTERVENTIONS**

Berger, R. E. & Berger, D. B. (1987). *BioPotency: A guide to sexual success.* Emmaus, PA: Rodale Press.

Tanagho, E.A., Lue, T. F. & McClure, R.D. (Eds.). (1988). *Contemporary management of impotence and infertility*. Baltimore, MD: Williams & Wilkins.

A. Drug therapies.

Buffum, J. (1982). Pharmacosexology: The effects of drugs on sexual function-A review. Journal of Psychoactive Drugs, 14(3).

Crenshaw, T.L., Goldberg, J.B., & Stern, W.C. (1987). Pharmacologic modification of psychosexual dysfunction. Journal of Sex and Marital Therapy, 13. 239.

1. Hormonal therapy

*a)*Injection of testosterone enanthate in males with low testosterone levels. May still be the first proposed intervention for any male sex problem seen by the primary care physician or urologist.

*b)*Estrogen replacement therapy for females with deficiency

2. Intracavernosal self-injection of penis with vasodilators (papaverine, phentolamine, or prostaglandin E1) produces erection

Althof, S.E., Turner, L.A., Levine, S.B., Risen, C.B., Bodner, D.R., Kursh, E.D., & Resnick, M.I. Sexual, psychological, and marital impact of self-injection of papaverine and phentolamine: A long-term study. Journal of Sex and Marital Therapy, 17(2). 81-93.

3. Dopamine agonists

*a)*Levodopa, prescribed in Parkinson's disease.

b) Bromocriptine therapy for hyperprolactinemia. Patient complaint may be situational erectile dysfunction, resembling psychogenic etiology, but resulting from pituitary tumor.

Schwartz, M.F., Bauman, J.E., & Masters, W.H. (1982). Hyperprolactinemia and sexual disorders in men. Biological Psychiatry, 17. 861-876.

*c)*Deprenyl (selegeline) used in Parkinson's disease, appears to correct age-related decline in sexual function, may increase lifespan. No side effects have been reported.

Knoll, J. (1985). The facilitation of dopaminergic activity in the aged brain by deprenyl: A proposal for a strategy to improve the quality of life in senescence. Mechanisms of Ageing and Development, 30(109).

d. Amphetamines, commonly used for suppressing appetite, appear to increase sexual desire.

Angrist, B.M. & Gershon, S. (1976). Clinical effects of amphetamine and L-dopa on sexuality and aggression. Comprehensive Psychiatry, 17. 715-722.

4. Yohimbine, an alpha-2-adrenergic receptor blocker, increases blood flow, is prescribed (probably widely) for erectile dysfunction. Side effects include changes in blood pressure, which may be risky for the aging males for whom it is prescribed.

5.Nitroglycerine, in oral or transdermal (paste,) in the treatment of erectile dysfunction

Morales, A., Condra, M.S., Owen, J.E., et al., (1988). Oral and transcutaneous pharmacologic agents in the treatment of impotence. Urol. Clin. N. America, 15(1). 87.

6. Alpha-adrenergic stimulants, e.g., imipramine (Tofranil), for retrograde ejaculation, which may occur as a result of anticholinergic drugs (and after some prostate surgeries and as a consequence of diabetic neuropathy), can sometimes restore normal emission.

Goldwasser, B., Madgar, I., Jonas, P., Lunenfeld, B., & Many, M. (1983). Imipramine for the treatment of sterility in patients following retroperitoneal node dissection. Andrologia, 15. 588-591.

7. Antiandrogens, used for controlling the behavior of sex offenders (chemical castration). Pedophiles are the usual candidates.

a) Medroxyprogesterone acetate (MPA)-Depo-Provera.

b) Cyproterone acetate (CPA)

Cooper, A.J. (1986). Progestogens in the treatment of male sex offenders: A review. Canadian Journal ofPsychiatry, 31(1), 73-79.

8.Serotonergic medications are used to control compulsive sexual behavior.

Coleman, E. (1991). New directions in sex therapy. Free Inquiry, 11(4). 36.

B. Mechanical devices, used by males for penetration sex

1. External management devices

a) Negative pressure/tension band devices e.g., Erec-Aid System, Vacuum Erection Device, Pos-T-Vac System

b) Tension bands, rings, used alone to entrap blood after erection is achieved

*c)*Silicon sheath (external splint) supports flaccid penis

2. Penile implants-devices surgically placed internally

a) Inflatable

Engel, R & Fein, R. (1990). Mentor GFS inflatable prosthesis. *Urology (35)5*. 405-406.

b) Non-inflatable-semi-rigid, hinged, or malleable

MacKenzie, B. & MacKenzie, E., with Christie, L. (1988). It's not all in your head: A couple's guide to overcoming impotence. New York: E.P. Dutton.

C. Other surgical interventions

1. Penile arterial revascularization for the management of penile vascular insufficiency

2. Penile vascular ligation for corpus spongiosum venous leakage

D. Impotence support groups (supported by prosthesis manufacturers, urologists, and hospitals where implant surgery is performed)

(1987). Medical marketing: Impotence support groups - a win-win situation. Sexuality & Disability, 8(4). 235.

E. Body therapies are in wide use for teaching sensuality and how to achieve orgasm. Since the public and the media associate these methods with the profession of sex therapist, and they are a focus of controversy in clinical sexology, the body therapies are outlined here.

Theory:

Goodson, A. (1991). *Therapy, nudity and joy: The Therapeutic use of nudity through the ages from ancient ritual to modern psychology.* Los Angeles: Elysium Growth Press.

Montagu, A. (1986). *Touching: The human significance of skin.* New York: Harper & Row.

1. Hands-on healing can break sexual barriers. Sexuality is a combination of mind, body, and spiritual energies; imbalances and blocks in the energies create poor functional patterns. Body therapies may include light touch, deep stimulation, skeletal adjustment, chakra/aura balancing, combination therapies, and spiritual energizing techniques.

2. Massage

a. Non-verbal communication and stimulation, involving both conscious and subconscious neurochemical pathways. Energies may be added with music, aromatherapy, color therapy, subliminal tapes, hypnotic tapes, TENS stimulation, mechanical vibrators, oils, and hydrotherapy. Over two dozen massage systems derive from Native American, Oriental, Swedish, Esalen, reflexology, and physical medicine.

b. In order to refer responsibly and with confidence, sex therapists must experience the effects of several modes of body healing.

Downing, G. (1972). *The massage book*. New York: Random House.

Feltman, J. (1989). *Hands-on healing*. Emmaus, PA: Rodale Press.

3. Chiropractic. Sexual disorders are reported improved (26% to 34%) after chiropractic therapy. Most chiropractors do not treat sex problems; they are good referral sources.

4. Accupressure is used for relaxation and relief of mild pain and tension. Japanese accupressure (shiatsu) involves vigorous body manipulation and pressure. Relief of vaginismus, psychological impotence, and performance anxiety is reported. Meditative accupressurists "expound sexual energy balances" through tantric cosmic sex yoga. Some accupressure parlors deal only with quick relief of sexual tensions.

5. Neo-Reichian, also called orgonomy and bioenergetics. Goals are "perfect genitality" and to break down "mind-body armor" to achieve "perfect sexuality," using new energy delivery and balancing devices such as biocircuits, biomagnetic energizers, crystals, and pyramidal systems.

Patten, L. & Patten, T. (1988). *Biocircuits*. Tiburon, CA: H.J. Kramer.

6. Feldenkrais method, Hellerwork, Trager method, and Rolfing are said to improve sexual function. Feldenkrais method, recommended for sex problems after chemotherapy, uses deep muscle manipulation without the pain of Rolfing. Hellerwork is recommended for problems following incest, Trager method where there are cardiopulmonary problems affecting sexual response.

Heartwood Institute. Catalog: *Your guide to intensive programs*. Garberville, CA: Heartwood Institute.

7. Universal Life Force therapies include Reiki, Mahikari, and aura (matrix) balancing-which deal with the "quantum energy of vibrational medicine." The Reiki Master Teacher delivers pure life energy (God or love) to the client, either in a hands-on setting or over any distance.

Haberly, H.J. (1990). *Reiki: Hawayo Takata's story*. Garrett Park, MD: Archedigm Publications.

8. Sensate Therapy. "Combines Eastern meditation techniques and spirituality concepts with sensate focus exercises, relaxation techniques, sensory awareness, and nurturing rituals."

Stubbs, K.R. (1991). *Erotic massage: The touch of love*. Berkeley, CA: Secret Garden.

G. Aphrodisiacs.

McIlvenna, R.T. (1988). T*he pleasure quest: The search for aphrodisiacs*. San Francisco: Specific Press.

Taberner, P.V. (1985). *Aphrodisiacs: The science and the myth*. Philadelphia: University of Pennsylvania Press.

Yates, A. & Wolman, W. (1991). Aphrodisiacs: Myth and reality. Medical Aspects of Human Sexuality,25(12). 58-64.

H. Imprisonment and institutionalization are historically, and probably to this day, the most frequently employed methods for changing sexual behavior.

Gebhard, P.H., Gagnon, J.H., Pomeroy, W.B., & Christenson, C.V. (1965). *Sex offenders*. New York: Harper & Row.

VII. **SEX THERAPY OUTCOME STUDIES**. Cole and Dryden describe striking differences between research in human sexual behavior, which recognizes the rigors and restraints of empirical science, and research in sex therapy (in the U.S. and England), which is generally less disciplined, subject to the aspirations of therapists, and often sacrificing objectivity at the alter of therapeutic wishful thinking. Helping practitioners do not cite research findings as a major source of influence in their therapeutic practice.

Cole, M. & Dryden, W. (1988). Sex therapy: A research overview. In M. Cole & W. Dryden, *Sex therapy in Britain*. Philadelphia: Open University Press, Milton Keyes. 337-351.

Kilmann, P. R., Boland, J. P., Norton, S. P., Davidson, E., & Caird, C. (1986). Perspectives on sex therapy outcome: A survey of AASECT providers. Journal ofSex and Marital Therapy, 12. 116-138.

O'Carroll, R. (1991). Sexual desire disorders: A review of controlled treatment studies. Journal of Sex Therapy, 28(4). 607-621.

VIII. **DRUGS THAT MAY DISTURB SEXUAL FUNCTIONING.** Some people seem to be exquisitely sensitive to a particular drug effect, others remain functional regardless of dose. Since sexual dysfunction appears to be common in the general population, and medications are used by ill individuals whose physiological and psychological processes are challenged by factors other than the medications, it is probably not often reasonable to attribute impaired sexual functioning to a particular drug. Following is a list of pharmaceuticals which may adversely affect desire, arousal, or orgasm.

A. Prescription drugs

1. Alpha blockers (Dibenzyline)

2. Antianxiety agents (Sinequan, Valium, Xanax)

3. Antibiotics (may lead to yeast infections, dyspareunia)

4. Anticholinergic agents (Atropine, Banthine, Cantil, Homapin, Pro-Banthine)

5. Anticonvulsants (Dilantin)

6. Antidepressants (Prozac, Anafranil, Ascendin, Aventyl, Elavil, Eskalith, Eutonyl, Marplan, Nardil, Norpramin, Pamelor, Parnate, Tofranil)

7. Antipsychotic agents (Haldol, Mellaril, Quide, Serentil, Taractan, Thorazine, Trilafon)

8. Cardiovascular agents

*a)*Antiarrhythmics (Norpace)

b) Antihypertensives (Aldomet, Apresoline, Catapres, Ismelin, Minipress, Normodyne, Serpasil)

*c)*Beta-blockers (Blocadren, Inderal, Normodyne, Tenormin, Timoptic)

d) Cardiotonics (Lanoxin)

*e)*Diuretics (Aldactone, HydroDIURIL, Hygroton, Oretic)

9. Glaucoma drugs (Diamox, Neptazane)

10. Histamine receptor blocking agents (Tagamet, Zantac)

11.Hormonal preparations (anabolic steroids, estrogens in men, hydroxyprogesterone, progesterone)

12. Lipid-lowering agent (Atromid-S)

13. Nonsteroidal anti-inflammatory agents (Naprosyn)

B. Over-the-counter drugs (antihistamines in prolonged use)

C. Recreational drugs

1. Alcohol-has direct destructive effect on neurogenic reflex that produces erection; damage is irreversible for many. In women, causes inhibited desire, orgasmic dysfunction, dyspareunia.

2. Spanish Fly (cantharides), toxic, has caused priapism and permanent penile damage.

3. Amyl nitrate: has caused myocardial infarction

4. Cocaine: chronic use decreases sexual function and interest.

5. Marijauana: regular use decreases plasma testosterone levels.

6. Heroin and methadone: cause dysfunction of erection and emission in men. In women: amenorrhea, infertility, reduced sexual desire and sensation, spontaneous abortions.

Crenshaw, T. (1996). *Sexual pharmacology: Drugs that affect sexual function.* New York: Norton.

Rogers, A. (1990). Drugs and disturbed sexual functioning. In C.I. Fogel & D. Lauver (Eds.). *Sexual health promotion.* Philadelphia: W.B. Saunders.

Rogers, A. (1997). *Physician's Desk Reference.* Montvale, NJ: Medical Economics.

IX. **PRIVATE PRACTICE DEVELOPMENT AND MANAGEMENT**

Beigel, J.K. & Earle, R.H. (1991). *Successful private practice in the 1990s: A new guide for the mental health professional.* New York: Brunner/Mazel.

Browning, C.H. & Browning, B.J. (1986). *Private practice handbook: The tools, tactics & techniques for successful practice development*, 3rd ed. Los Alamitos, CA: Duncliff's International.

Wincze, J.P. & Carey, M.P. (1991). Continued professional development and practice. In J.P. Wincze & M.P. Carey, *Sexual dysfunction: A guide for assessment and treatment.* New York: Guilford Press.

Chapter 7

CLINICAL MANAGEMENT OF SEXUAL TRAUMA, CHRONIC DISABILITY AND DISEASE

I.COERCIVE SEX

A.Rape: acquaintance, date, and stranger

Brownmiller, S. (1975). *Against our will: Men, women, and rape.* New York: Simon & Schuster.

Palmer, C.T. (1988). Twelve reasons why rape is not sexually motivated: A skeptical examination. TheJournal of Sex Research, 25(4). 512-530.

Parrot, A. (1988). *Coping with date rape and acquaintance rape.* New York: Rosen Publishing.

Weinstein, E. & Rosen, E. (1988). Counseling victims of sexual assault. In E. Weinstein & E. Rosen (Eds.), *Sexuality counseling: Issues and implications.* Pacific Grove, CA: Brooks/Cole.

B.Incest and child sexual abuse

Finkelhor, D. (1979). *Sexually victimized children.* New York: The Free Press/Macmillan.

Meiselman, K. (1978). *Incest.* San Francisco: Jossey-Bass.

Sgroi, S.M. (1982). *Handbook of clinical intervention in child sexual abuse.* Lexington, MA: Lexington Books.

Walters, D. (1976). *Physical and sexual abuse of children.* Bloomington, IN: Indiana University Press.

1.Pre-pubescent/adult sexual contacts

Coloa, F. & Hosansky, T. (1983). *Your children should know.* New York: Bobbs Merrill.

2.Post-pubescent/adult sexual contacts

Prendergast, W. (1996). *Sexual abuse of children and adolescents.* New York: Continuum.

C.Sexual coercion in institutions

O'Day B. (1983). *Preventing sexual abuse of persons with disabilities.* Santa Cruz, CA: Network Publications.

Shore, D.A. (1984). Sex in institutions: Expanding the parameters of sex and disability. In M. Tallmer et al. (Eds.). *Sexuality and life-threatening illness.* Springfield, IL: Charles C. Thomas, 127-147.

D.Sexual coercion in marriage

Bowker, L. (1987). *Considering marriage: Avoiding marital violence.* Santa Cruz, CA: Network Publications.

Martin, D. (1981). *Battered wives,* (updated ed.). San Francisco: Volcano Press.

Domestic Violence
http://www.hky.com/domestic.html

E.Adult victims of sexual violence

Courtois, C.A. (1988). *Healing the incest wounds:Adult survivors in therapy.* New York: Norton.

Kirschner, S., Kirschner, D.A., & Rappaport, R. L. (1993). *Working with adult incest survivors.* New York: Brunner/Mazel.

Lew, M. (1990). *Victims no longer: Men recovering from incest and other child sexual abuse.* New York:
Harper & Row.

Sexual Violence
http://www.public.asu.edu/~ide4bubu/sexlinks/violence.html

F.Adults sexually abused as children

Jehu, D. (1988). *Beyond sexual abuse: Therapy with women who were childhood victims.* Somerset, NJ: John Wiley.

Josephson, G.S. & Fong-Beyette, M.L. (1987). Factors assisting female clients' disclosure of incest during counseling. Journal of Counseling and Development,65. 475-478.

Maltz, W. (1991). *The sexual healing journey.* New York: Harper Collins.

G.Prevention

Ammerman, R. T. & Hersen, M. (1990). *Treatment of family violence.* New York: Wiley.

Ammerman, R. T. & Hersen, M. (1992). *Assessment of family violence.* New York: Wiley.

H.Sex offenders

Gagne, P. (1981). Treatment of sex offenders with medroxyprogesterone acetate. American Journal ofPsychiatry, 138. 644-646.

I.Domestic violence: partner abuse, spousal abuse and battering refer to violence between partners in an ongoing relationship.

(1992). American Medical Association. *Diagnostic and treatment guidelines on domestic violence.* Chicago: AMA.

(1993). Developments in the law: A legal response to domestic violence, III. Harvard Law Review, (106), 1528.

(1995). Domestic violence. Technical Bulletin No.209. Washington, DC: ACOG.

Hotlines:Stop Domestic Violence
1 (800) 799-SAFE (7233)
1 (800) 787-3224 (TDD)

For state coalition telephone numbers, contact: National Coalition Against Domestic Violence
P.O. Box 15127
Washington, DC 20003-0127
(202) 293-8860

II.**DISABILITY : CHRONIC DISEASE**

INTRODUCTION

Since chronic illness tends to progress slowly over a period of years, changes in sexual functioning may develop insidiously. People who have chronic diseases and those with whom they are intimate often have inaccurate or incomplete information about the impact of their illness on sexual expression and they may know little about what treatment options are available. Accurate information is key in dispelling the myths and misconceptions.

Fogel, C. I. & Lauver, D. (Eds.). (1991). *Sexual health promotion*. Philadelphia: W.B. Saunders.

Johnson, W.R. (1981). *So desperate the fight: An innovative approach to chronic illness*. New York: Institute for Rational Living.

Kolodny, R. C., Masters, W. H., and Johnson, V. E. (1979). *Textbook of sexual medicine*. Boston: Little, Brown.

Schover, L. R. & Jensen, S. B. (1988). *Sexuality and chronic illness: A comprehensive approach*. New York: Guilford.

Tallmer, M. et al. (1984). *Sexuality and life-threatening illness*. Springfield, IL: Charles C. Thomas.

Books on Sex and Disabilities
http://www.drruth.com:80/picks/books/disabilities.html

Disabilities, Illnesses, and Sex
http://www.public.asu.edu/~ide4bubu/sexlinks/disabil.html

A.Effects of Chronic Disease

1.Impairment: loss of automatic and volitional ability.

2.Disability: Loss of activity and ease of ability.

3.Handicap: Loss of interaction with the environment.

III.**CHRONIC DISEASES**

A.Cardiovascular disease.

Burke, L.E. (1990). Cardiovascular disturbances and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*, Philadelphia: W.B. Saunders.

B.End-stage renal disease (ESRD).

Ayres, T. and Nowinski, J.K. (1981). Sex therapy and end-stage renal disease. In D.G. Bullard & S.E. Knight, *Sexuality and physical disability: Personal perspectives and professional issues*. St. Louis: C.V. Mosby.

C.Cancer.

Schour, L. (1988). *Sexuality and cancer.* New York: American Cancer Society.

Stoklosa, J. M., Bullard, D. G., Rosenbaum, E. H., and Rosenbaum, I. R. (1979). *Sexuality and cancer.* Palo Alto, CA: Bull Publishing.

D.Diabetes.

Whitehead, E.D. When your diabetic patient becomes impotent. Medical Aspects of Human Sexuality, 25(5). 52-58.

E.Chronic obstructive pulmonary disease.

F.Chronic pain.

G.Genitourinary infections.

1.Vaginitis.

(1994). Vaginitis: Causes and treatments. ACOG Patient Education (APO28). Washington, DC: ACOG.

2.Cystitis.

3.Prostatitis.

H.Multiple Sclerosis (MS)

I.Osteoporosis

J.Rheumatoid Arthritis (RA)

K.Systemic Lupus Erythematosus

L.Major psychiatric disorders

Johnson, W.R. & Kemp, W. (1981). *Sex education and counseling of special groups: The mentally and physically handicapped, ill and elderly.* Springfield, IL: Charles C. Thomas.

IV.**SEX AND INJURY: PHYSICAL IMPAIRMENT**

Cole, T.M. & Cole, S.S. (1981). Sexual adjustment to chronic disease and disability. In W.C. Stolov and M.R. Clowers (Eds.), *Handbook of severe disability.* University of Washington Department of Rehabilitation. 279-287.

Gething, L. (1992). *Person to person: A guide for professionals working with people with disabilities*. Baltimore, MD: Paul H. Brookes Publishing Co.

Haseltine, F. P., Cole, S.S., & Gray, D.B. (1993). *Reproductive issues for persons with physical disabilities*. Baltimore, MD: Paul J. Brookes Publishing Co.

Sanford, W. & Iazzetto, D. (1992). Body image. In E. Rome, *The new our bodies, ourselves*. New York: Touchstone. 23-29.

Sex and disability: Those people....I-IV. Eric Miller, Co.,P.O. Box 443, Narberth, PA 19072.

Sexuality reborn. Kessler Institute for Rehabilitation, 1999 Pleasant Valley Way, West Orange, NJ 07052, attn: Craig Alexander, Ph.D., or M. Sipski, M.D.

A.Spinal cord injury (SCI): Sexual function will depend on the location and severity of the injury, and there is a great variation even for women with injuries at the same spinal level. If injury is above the sacral area, there will be reflex sexual responses, and at or below this level (conus medullaris), reflex responses will be disrupted. SCI may result in paralysis, spasticity, loss of sensation, incontinence, skin ulcers, pain and a dry vagina.

Leyson. J.F.J. (Ed.). (1991). *Sexual rehabilitation of the spinal cord patient*. Clifton, NJ: Humana Press.

Mooney, T.D., Cole, T.M., & Chilgren, R.A. (1975). *Sexual options for paraplegics and quadriplegics*. Boston: Little, Brown and Co.

B.Traumatic brain injury (TBI)

Griffith, E.R. & Lemberg, S. (1992) *Sexuality and the person with traumatic brain injury*. Philadelphia, PA: F.A. Davis, Co.

V.**SEX AND IMPAIRED SENSES**

A.Deaf

Fitz-Gerald, D. & Fitz-Gerald, M. (1976). Sex education survey in residential facilities for the deaf. American Annals of the Deaf, 121(5). 480-483.

B. Blind

VI. **RESOURCES**

A. Healthcare for women

American College of Obstetricians and Gynecologists
409 12th Street, S.W.
Washington, DC 20024-2188

B. Healthcare for men

American Urological Association
Office of Education
1 (800) 282-7077

C. Sexually transmitted diseases/HIV-AIDS

American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709

D.Child victims of incest and sexual abuse

National Resource Center on Child Sexual Abuse
2204 Whitesburg Drive, Suite 200
Huntsville, AL 35801

Chapter 8

PARAPHILIAS

I.SEXUALLY UNUSUAL, NON-COERCIVE BEHAVIORS

Dailey, D.M. (1988). *The sexually unusual: Guide to understanding and helping.* New York: Haworth Press.

A.Defining normality

B.Labeling and stigmatization. Formerly labeled sexual variations, paraphilias, and perversions.

C.Paraphilias[5]: Refers to recurrent responsiveness to and obsessive dependence on an unusual or socially unacceptable stimulus in order to experience sexual arousal and achieve orgasm.

Though many of the paraphilic behaviors are thought of as problems, deviations, or perversions (by some) and listed as such in DSM-IV, these same acts are enjoyed as enhancements of sexual experience--especially in safer sex scenarios.

Cornog, M., Perper, T., & Scherzer, N.A. (Eds.). (1995). *The complete dictionary of sexology,* (new expanded edition). New York: Continuum.

Ellis, H. (1936). *Studies in the psychology of sex.* New York: Random House.

Kraft-Ebing, R. (1937). *Psychopathia sexualis.* New York: Physicians and Surgeons Book Co.

Money, J. (1986). *Gay, straight and in-between.* New York: Oxford.

[5](1994). *Diagnostic and Statistic Manual of Mental Disorders,* (4th ed.). Washington, DC: American Psychiatric Association.

Money, J. (1993). *Lovemaps.* New York: Irvington Publishers, Inc.

Sacher-Masoch, L. (1989). *Venus in furs.* New York: Blast Books, Inc.

Ullerstam, L. (1966). *The erotic minorities.* New York: Grove Press.

Sade, Marquis de. (1966). *120 days of Sodom and other writings.* New York: Grove Weidenfeld.

Stekel, W. (1930). *Sexual aberrations.* New York: Liverworth.

Albert Ellis Institute
http://www.irebt.org/

1.Exhibitionism (302.4): Repetitive acts of genital exposure to an unsuspecting stranger for the purpose of producing sexual excitement.

2.Fetishism (302.81): The use of non-living objects as the preferred exclusive method of producing sexual excitement..

Thompson, M. (1991). *Leatherfolk.* Boston: Alyson.
Erotika Groove Society
http://www.infobahnos.com/~fetishad/events.htm

Sexuality Library Washington University
http://weber.u.washington.edu/~sfpse/ftpsite.html#fetish

3.Frotteurism (302.89): Rubbing against a stranger.

4.Pedophilia (302.2):A preference for repetitive sexual activity with prepubertal children.

Rayfield, D. (Ed., transl.). (1985). *The confessions of Victor X.* New York: Grove Press.

5.Sexual masochism (302.83): Intentional participation in an activity in which the individual is physically harmed or the individual's life is threatened in order to produce sexual excitement, or if the preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer.

6.Sexual sadism (302.84): The inflicting of physical or psychological suffering on the sexual partner as a method of stimulating sexual excitement and orgasm.

Granzig, W. (1997). Leather language: A clinician's guide to S/M terminology. CliniScope; The American

Academy of Clinical Sexologists: Clinical Monograph, 5.

Greene, C. & Greene, G. (1973). *S-M: The last taboo.* New York: Grove Press.

Moser, C. & Levitt, E.E. (1987). An exploratory-descriptive study of a sadomasochistically oriented sample. The Journal of Sex Research, 23. 322-337.

Weinberg, T. & Kamel, G.W. (1983). *S & M: Studies in sadomasochism.* New York: Prometheus.

7.Voyeurism (302.82): Sexual arousal by looking at an unsuspecting females who are naked, disrobing or engaging in sexual activity..

8.Transvestism (302.3): Dressing by heterosexual males in female clothes.

Feinbloom, D.H. (1976). *Transvestites and transsexuals: Mixed views.* New York: Delta.

Peo, R. (1993). Clinical intervention with male transvestites and their female partners.. CliniScope;The American Academy of Clinical Sexologists:Clinical Monograph, 1.

Prince, V. (1976). *Understanding transvestism.* Los Angeles: Chevalier.

Riddle, G.C. (1989). *Amputees and devotees.* New York: Irvington Publications.

Panties Just For Men: Elegant fashions at an everyday low price.
http://members.aol.com/PJMFashion/index.htm

9.Other paraphilias[6]

*a)*Acrotomophilia (amputee partner)

*b)*Adolescentilism (impersonating an adolescent)

*c)*Andromimetophilia (male impersonators partner)

*d)*Apotemnophilia (self-amputee)

*e)*Asphyxiophilia (asphyxiation)

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[6]Money, J. (1988). *Gay, straight, and in-between.* New York: Oxford University Press.

Money, J. (1991). *The breathless orgasm: A lovemaps biography of asphyxiophilia.* New York: Prometheus.

*f)*Autagonistophilia (live-show self display)

*g)*Autassassinophilia (self-staged own death)

*h)*Autonepiophilia (infantilism, wearing diapers)

Diaper Pail Friends
http://www.dpf.com/

*i)*Biastophilia (raptophilia)

*j)*Catheterophilia (catheter)

*k)*Chrematistophilia (blackmail payment)

*l)*Chronophilia (age discrepancy)

*m)*Coprophilia (feces)

*n)*Ephebophilia (adolescent partner)
*o)*Erotophonophilia (lust murder)

*p)*Formicophilia (crawling things)

*q)*Gerontophilia (parent-aged partner)

*r)*Gynemimetophilia (female-impersonator partner)

*s)*Hybristophilia (criminal or convict partner)

*t)*Hyphephilia (tactile fetish)

*u)*Hypoxyphilia (asphyxiophilia)

*v)*Infantilism (impersonating a baby)

*w)*Kleptophilia (stealing)

*x)*Klismaphilia (enema)

*y)*Mixophilia (scoptophilia)

*z)*Morphophilia (physique discrepancy)

*aa)*Mysophilia (filth)

*bb)*Narratophilia (erotic story telling)

*cc)*Necrophilia (corpse)

*dd)*Nepiophilia (infant partner, diaper-aged)

*ee)*Olfactophilia (smell fetish)

*ff)*Pedophilia (juvenile partner)

*gg)*Peodektophilia (penile exhibitionism)

*hh)*Pictophilia (erotic graphics or films)

*ii)*Raptophilia (rape, biastophilia)

*jj)*Scoptophilia (onlooker, mixophilia)

*kk)*Somnophilia (sleeping partner)

*ll)*Stigmatophilia (tattoo, piercing)

*mm)*Symphorophilia (disaster, conflagration)

*nn)*Telephonicophilia (lewd phone calling)

*oo)*Toucheurism (touching a stranger)

*pp)*Urophilia (urine)

*qq)*Zoophilia (animals)

Cerrone, G.H. (1991). Zoophilia in rural population: Two case studies. Journal of rural communitypsychology, 12(1). 29-39.

Dekkers, M. (1994). Translated by Vincent, P. *Dearest pet: On bestiality*. New York: Verso.

Ellis, A., Abarbanel, A., and Aronson, J. (Eds.). (1973). *Encyclopedia of sexual behavior*. NewYork: Jason Aronson.

Watson, P. (1981). *Bestiality among American women*. South Laguna, CA: Publisher's Consultants.

D.Sexual Addiction: Hypersexuality -- a focus of debate in the sex professions. One may ask, "How much joy is too much joy?" The answer depends on one's value system.

Carnes, P. (1983). *Out of the shadows: Understanding sexual addiction*. Minneapolis, MN: CompCare Publications.

Levine, M. P. & Toiden, R.R. (1988). *The myth of sexual compulsivity.* The Journal of Sex Research,25(3). 347-363.

Chapter 9

GENDER IDENTITY DISORDERS: TRANSSEXUALISM

I.INTRODUCTION

The causes of transsexualism are not yet fully understood. We only know that gender roles are established at a very early age and that, after a certain critical time has passed, a person's gender self-identification is irreversible. As far as we know, transsexualism is as old as mankind itself, although transsexuals have been treated very differently in different cultures and historical periods. Many sex researches today believe that transsexualism may be caused by a combination of biological and social factors, and that some children may develop a transsexual disposition even before they are born.

Benjamin, H. (1966). *The transsexual phenomenon.* New York: Ace Books.

Bolin, A. (1988). *In search of eve: Transsexual rites of passage.* South Hadley, MA: Bergin & Garvey.

Doctor, R.F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior.* New York: Plenum.

Haeberle, E.J. (1983). *The sex atlas,* (revised and expanded). New York: Continuum.

Money, J. (1988). *Gay, straight, and in-between: The sexology of erotic orientation.* New York: Oxford University Press.

II.DEFINING TRANSSEXUALISM

A.Transsexualism: The condition of experiencing a persistent and profound sense of discomfort and inappropriateness about his or her anatomical sex and feeling compelled to have that anatomy surgically altered in order to live biologically and socially as a member of the other sex.

B.Transsexual:A person manifesting the symptoms of transsexualism; a person more often male than female, whose gender identity conflicts with his or her external sexual anatomy and who seeks a sex reassignment operation; an individual gender cross-coded for his or her core-morphologic identity and gender-role behavior. A distinction is made by experts and transsexual advocates between preoperative and post operative transsexual depending on whether they have had sex change surgery.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders,* (4th ed.). Washington, DC: American Psychiatric Association.

Bullough, V.L. & Bullough, B. (1993). *Cross-dressing, sex, and gender.* Philadelphia, PA: University of Pennsylvania Press.

Meyer-Bahlburg, H.F.L. (1993). Gender identity development in intersex patients. Child and Adolescent Psychiatric Clinics of North America, 2. 501-512.

University of Washington Library, Transgenderism

http://weber.u.washington.edu/~sfpse/ftpsite.html#transgen

III.**CLINICAL IMPLICATIONS**

Today, many professionals feel that transsexuals should be helped to achieve, or at least approach, their goal. Or, as a distinguished physician once put it: "If the mind cannot be changed to fit the body, then perhaps we should consider changing the body to fit the mind." Modern hormone therapy and new surgical techniques have now made it possible to alter a person's anatomical appearance considerably.

Annon, J.S. (1974). The behavioral treatment of sexual problems, Vol. 1: Brief Therapy. Honolulu, HI: Enabling Systems.

Benjamin, H. (1955). Sex transformation (letter). JAMA, 158. 217.

Benjamin, H. (1964). Clinical aspects of transsexualism in male and female. American Journalof Psychotherapy, 18. 458-469.

Benjamin, H. (1969). For the practicing physician: Suggestions and guidelines for management of transsexuals. In R. Green & J. Money (Eds.), *Transsexualism and sex reassignment.* Baltimore, MD: Johns Hopkins University Press. 305-307.

Berlin, F.S. (1989). The paraphilias and depo-provera: Some medical, ethical and legal considerations. BullAmerican Academy of Psychiatry Law, 17. 233-239.

Blanchard, R., Legault, S., & Lindsay, W. (1987). Vaginoplasty outcome in male-to-female transsexuals. Journal of Sex and Marital Therapy, 13. 265-275.

Green, R. (1974). *Sexuality identity conflict in children and adults.* New York: Basic Books.

Schaefer, L.C. & Wheeler, C.C. (1995). Clinical historical notes: Harry Benjamin's first ten cases (1938-1953). Archives of Sexual Behavior, 24. 73-93.

Stoller, R.J. (1973). Male transsexualism: Uneasiness.American Journal of Psychiatry, 130. 536-539.

Wheeler, C.C. & Schaefer, L.C. (1984). The true transsexual and life-style options. In Z. Hoch (Ed.), *Sexual behavior.* London: Plenum.

Schaefer, L.C., Wheeler, C.C., & Futterweit, W. (1995). Gender identity disorders (transsexualism). In G.O. Gabbard, (Ed.), *Treatments of psychiatric disorders,* Vol. 2. Washington, DC: American Psychiatric Press, Inc.

University of Washington Library, Body Modification
http://weber.u.washington.edu/~sfpse/ftpsite.html#bodyart

http://www2.wintermute.co.uk/users/snuffles/The_Plaid/Medical/

SOC.html

IV.RESOURCES

Eakins, B.W. & Eakins, R.G. *Sex differences in human communications.* Boston: Houghton, Mifflin Company.

Frank, F. and Anshen, F. *Language of the sexes.* Albany, NY: State University of New York Press.

Price, V. *How to be a woman though male.* Los Angeles: Chevalier Publications.

Stevens, J. (1990). *From masculine to feminine and all points in between.* Different Path Press.

The Eden Society (a transsexual support group), Box 1692, Pompano Beach, Florida 33061, (954) 784-9316.

Chest Illusions
http://www.tiac.net/users/dba/mall/illusion/illusion.htm

Florida Resources
http://www.tiac.net/users/dba/resource/fl.htm

Gender Mall – Stores
http://www.tiac.net/users/dba/mall/main.htm

Genteel - Transgender Resource Guide
http://www.aaconsult.com/genteel/genteel/html

Chapter 10

DISABILITY : CHRONIC DISEASE

I.INTRODUCTION

Since chronic illness tends to progress slowly over a period of years, changes in sexual functioning may develop insidiously. People who have chronic diseases and those with whom they are intimate often have inaccurate or incomplete information about the impact of their illness on sexual expression and they may know little about what treatment options are available. Accurate information is key in dispelling the myths and misconceptions.

Fogel, C. I. & Lauver, D. (Eds.). (1991). *Sexual health promotion*. Philadelphia: W.B. Saunders.

Johnson, W.R. (1981). *So desperate the fight: An innovative approach to chronic illness*. New York: Institute for Rational Living.

Katzen, L. (1990). Chronic illness and sexuality. American Journal of Nursing, (January). 55-59.

Kolodny, R. C., Masters, W. H., and Johnson, V. E. (1979). *Textbook of sexual medicine*. Boston: Little, Brown.

Schover, L. R. & Jensen, S. B. (1988). *Sexuality and chronic illness: A comprehensive approach*. New York: Guilford.

Tallmer, M. et al. (1984). *Sexuality and life-threatening illness*. Springfield, IL: Charles C. Thomas.

Books on Sex and Disabilities
http://www.drruth.com:80/picks/books/disabilities.html

Disabilities, Illnesses, and Sex
http://www.public.asu.edu/~ide4bubu/sexlinks/disabil.html

A.Effects of Chronic Disease

1.Impairment: loss of automatic and volitional ability.

2.Disability: Loss of activity and ease of ability.

Ames, T.R., Hepner, P., Kaeser, F., & Pendler, B. (1988). *The sexual rights of persons with developmental disabilities: Guidelines for programming with severely impaired persons.* New York.

3.Handicap: Loss of interaction with the environment.

Bass, M.S. (1974). Sex education for the handicapped. The Family Life Coordinator, 1. 27-33.

Blum, G. & Blum, B. (1981). *Feeling good about yourself: A guide for people working with people who have disabilities,* (2nd. ed.). Mill Valley, CA: Feeling Good Associates.

Craft, M. & Craft, A. (1978). *sex and the mentally handicapped.* London, England: Routledge and Kegan.

Makelprang, R.W., Valentine, D. (Ed.). (1993). *Sexuality and disabilities: A guide for Human Service practitioners.* New York: The Haworth Press.

II.**CHRONIC DISEASE**

A.Cardiovascular disease.

Burke, L.E. (1990). Cardiovascular disturbances and sexuality. In C.I. Fogel & D. Lauver, *Sexual health promotion*, Philadelphia: W.B. Saunders.

B.End-stage renal disease (ESRD).

Ayres, T. and Nowinski, J.K. (1981). Sex therapy and end-stage renal disease. In D.G. Bullard & S.E. Knight, *Sexuality and physical disability: Personal perspectives and professional issues*. St. Louis: C.V. Mosby.

C.Cancer.

Stoklosa, J. M., Bullard, D. G., Rosenbaum, E. H., and Rosenbaum, I. R. (1979). *Sexuality and cancer*. Palo Alto, CA: Bull Publishing.

D.Diabetes.

Whitehead, E.D. When your diabetic patient becomes impotent. Medical Aspects of Human Sexuality, 25(5). 52-58.

E.Chronic obstructive pulmonary disease.

F.Chronic pain.

G.Genitourinary infections.

1.Vaginitis.

2.Cystitis.

3.Prostatitis.

H.Multiple Sclerosis (MS)

I.Osteoporosis

J.Rheumatoid Arthritis (RA)

K.Systemic Lupus Erythematosus

L.Major psychiatric disorders

Johnson, W.R. & Kemp, W. (1981). *Sex education and counseling of special groups: The mentally and physically handicapped, ill and elderly.* Springfield, IL: Charles C. Thomas.

1.Anorgasmia: A hypophilic condition marked by the absence of or inability to experience sexual orgasm. Anorgasmia may be primary or always present, secondary and occurring only with certain partners or in certain circumstances, or random. In men, anorgasmia is knows as orgasmic impotence or retarded or delayed ejaculation. In females, it is often confused with frigidity. The condition may result from a variety of organic and psychological causes.

2.Priapism: A rare, psychological condition involving prolonged and painful erection of the penis, usually without sexual desire. The origin and causes of priapism are usually unknown, although a lesion within the penis or in the central nervous system may be a factor. The condition almost always results in destruction of the spongy tissue of the penis and eventually in chronic impotence due to persistent congestion.

III.**SEX AND INJURY: PHYSICAL IMPAIRMENT**

Cole, T.M. & Cole, SS. (1981). Sexual adjustment to chronic disease and disability. In W.C. Stolov and M.R. Clowers (Eds.), *Handbook of severe disability.* University of Washington Department of Rehabilitation. 279-287.

Gething, L. (1992). *Person to person: A guide for professionals working with people with disabilities.* Baltimore, MD: Paul H. Brookes Publishing Co.

Gillespie, J. (1992). Physical Disability and the pressure to be phsycially "perfect." In E. Rome, *The new our bodies ourselves.* New York: Touchstone. 24-26.

(1992). Sex and physical disabilities. In E. Rome, *The new our bodies ourselves.* New York: Touchstone. 223-225.

Haseltine, F. P., Cole, S.S., & Gray, D.B. (1993).

Reproductive issues for persons with physical disabilities. Baltimore, MD: Paul J. Brookes Publishing Co.

Sanford, W. & Iazzetto, D. (1992). Body image. In E. Rome, *The new our bodies, ourselves.* Touchstone, New York: Touchstone. 23-29.

Sex and disability: Those people....I-IV. Eric Miller, Co.,P.O. Box 443, Narberth, PA 19072.

Sexuality reborn. Kessler Institute for Rehabilitation, 1999 Pleasant Valley Way, West Orange, NJ 07052, attn: Craig Alexander, Ph.D., or M. Sipski, M.D.

A.Spinal courd injury (SCI): Sexual function will depend on the location and severity of the injury, and there is a great variation even for women with injuries at the same spinal level. If injury is above the sacral area, there will be reflex sexual responses, and at or below this level (conus medullaris), reflex responses will be disrupted. SCI may result in paralysis, spasticity, loss of sensation, incontinence, skin ulcers, pain and a dry vagina.

Glass. D. D. (1990). Diagnosis of sexual dysfunction in spinal-cord injured women. In J.F. Leyson (Ed.), *Sexual rehabilitationof the spinal-cord-injured patient.* New York: The Humana Press, Inc. 131-147.

Leyson. J.F.J. (Ed.). (1991). *Sexual rehabilitation of the spinal cord patient.* Clifton, NJ: Humana Press.

Mooney, T.D., Cole, T.M., & Chilgren, R.A. (1975). *Sexual options for paraplegics and quadriplegics.* Boston: Little, Brown and Co.

Renshaw, D.C. (1990). Management of sexual dysfunction in spinally injured women.Diagnosis of sexual dysfunction in spinal-cord injured women. In J.F. Leyson (Ed.), *Sexual rehabilitationof the spinal-cord-injured patient.* New York: The Humana Press, Inc. 149-165.

B.Traumatic brain injury (TBI)

Griffith, E.R. & Lemberg, S. (1992). *Sexuality and the person with traumatic brain injury.* Philadelphia, PA: F.A. Davis, Co.

IV. **SEX AND IMPAIRED SENSES**

A. Deafness

Fitz-Gerald, D. & Fitz-Gerald, M. (1976). Sex education survey in residential facilities for the deaf. American Annals of the Deaf, 121(5). 480-483.

B. Visual impairment

Glass, D.D. (1984). Sexuality and visual impairment. Siecus Report (12)5/6.

ADDENDUM

AMERICAN BOARD OF SEXOLOGY
STANDARDS OF TRAINING AND EDUCATION
FOR DIPLOMATES

I.Requirement for Diplomate Status. Effective since January 1, 1990, the requirements for Diplomate status in the American Board of Sexology are:

A.A candidate must have an earned **doctorate or terminal degree** in an appropriate field.

B.Candidates must have completed **one hundred twenty (120) hours** of sexological core courses.

C.Successful completion of **written and oral examinations** in general sexology and the appropriate specialty area (sex education, sex counseling, sex therapy or sex research).

D.Obtain three professional endorsements by Diplomates of The American Board of Sexology who are familiar with the methods and techniques of the candidate.

E.In addition to the above four (4) general requirements, candidates for the specialty areas of clinical sexologist (counseling or therapist), educational sexologist and sexological researcher must fulfill additional requirements which are:

1.**For Clinical Sexologists: Therapy**

*a)*Have three (3) years of professional clinical practice in sex therapy including one hundred fifty (150) hours of supervised practice.

*b)*One hundred (100) hours on theory, methods and techniques of sex therapy.

2.**For Clinical Sexologist: Counseling**

*a)*Have three (3) years of professional counseling experience including one hundred fifty (150) hours of supervised practice.

*b)*One hundred (100) hours of theory, methods and techniques of sex counseling.

3.**For Sexology Educators:**

*a)*Have a current academic appointment at the assistant professor or higher rank.

*b)*Have three (3) years teaching experience in human sexuality at an institution of higher learning.

4.**For Sexological Researchers:**

*a)*Have three (3) years experience in research in the field of human sexuality.

*b)*Provide evidence of publication of research results in a professional journal or other publication in the field.

II.Other Publication by The American Board of Sexology:

A.**The Registry of Diplomates**. This is a listing of all Diplomates of the Board who are currently certified. It is published annually in the Fall. It lists certified clinical sexologists, sex educators and sex researchers by state and provides information appropriate for selecting professionals such as name, address, phone, degree, schools attended, specialities and other useful information. Journalists and broadcast media producers will also find the Registry useful in selecting experts for appearance or interviews.

B.**The DIPLOMATE**. This is a newsletter of interest to Diplomates and consists of news for and about those certified by The American Board of Sexology. It is published quarterly.

C.**The American Academy of Clinical Sexologists**, the fellowship organization affiliated with The American Board of Sexology, publishes:

1. **The Journal of Sex and Marital Therapy**. This is a professional journal publishing research and reviews or work currently taking place in the scientific study of sex. It is published quarterly by Brunner-Mazel, 19 Union Square West, 115th Street, 8th Floor, New York, New York 10003. Phone: (212) 924-3344.

2.**CliniScope**. A clininical monograph of interest to fellows of The American Academy of Clinical Sexologists.

D.**How to get more information about certification**. The American Board of Sexology requirements for certification are outlined on the previous page. Those who meet the requirements and wish to become certified in any of four categories mentioned may write or call the Executive Director for an application form, or make inquiries if there are questions still unanswered about the process.

Or,

The American Board of Sexology
1929 18th Street N.W.
Suite 1166
Washington, DC 20009

The American Board of Sexology
Diplomae Newsletter
P.O. Box 1166
Winter Park, Florida 32790-1166
Phone: (212) 462-2122 FAX: (407) 628-5293

Internet Website: http://www.sexologist.org
E-mail: billeast@ctinet.net