Homosexuality

'Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons'

(Issued by the Vatican Congregation for the Doctrine of the Faith)

NC News Service

This is the Vatican text of the "Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons," issued by the Vatican Congregation for the Doctrine of the Faith. It was dated Oct. 1 and made public at the Vatican Oct. 30.

1.) The issue of homosexuality and the moral evaluation of homosexual acts have increasingly become a matter of public debate, even in Catholic circles. Since this debate often advances arguments and makes assertions inconsistent with the teaching of the Catholic Church, it is quite rightly a cause for concern to all engaged in the pastoral ministry, and this congregation has judged it to be of sufficiently grave and widespread importance to address to the bishops of the Catholic Church this letter on the pastoral care of homosexual persons.

2.) Naturally, an exhaustive treatment of this complex issue cannot be attempted here, but we will focus our reflection within the distinctive context of the Catholic moral perspective. It is a perspective which finds support in the more secure findings of the natural sciences, which have their own legitimate and proper methodology and field of inquiry.

However, the Catholic moral viewpoint is founded on human reason illumined by faith and is consciously motivated by the desire to do the will of God our Father. The Church is thus in a position to learn from scientific discovery but also to transcend the horizons of science and to be confident that her more global vision does greater justice to the rich reality of the human person in his spiritual and physical dimensions, created by God and heir, by grace, to eternal life.

It is within this context, then, that it can be clearly seen that the phenomenon of homosexuality, complex as it is, and with its many consequences for society and ecclesial life, is a proper focus for the Church's pastoral care. It thus requires of her ministers attentive study, active concern and honest, theologically well-balanced counsel.

3.) **EXPLICIT TREATMENT** of the problem was given in this congregation's *Declaration on Certain Questions Concerning Sexual Ethics* of Dec. 29, 1975. That document stressed the duty of trying to understand the homosexual condition and noted that culpability for homosexual acts should only be judged with prudence. At the same time the congregation took note of the distinction commonly drawn between the homosexual condition or tendency and individual homosexual actions. These were described as deprived of their essential and indispensable finality, as being "intrinsically disordered," and able in no case to be approved of (cf. No. 8, S 4).

> "Although the particular inclination of the homosexual person is not a sin, it is a more or less strong tendency ordered toward an intrinsic moral evil and thus the inclination itself must be seen as an objective disorder."

In the discussion which followed the publication of the declaration, however, an overly benign interpretation was given to the homosexual condition itself, some going so far as to call it neutral, or even good. Although the particular inclination of the homosexual person is not a sin, it is a more or less strong tendency ordered toward an intrinsic moral evil, and thus the inclination itself must be seen as an objective disorder.

Therefore special concern and pastoral attention should be directed toward those who have this condition, lest they be led to believe that the living out of this orientation in homosexual activity is a morally acceptable option. It is not.

4.) **AN ESSENTIAL DIMENSION** of authentic pastoral care is the identification of causes of confusion regarding the Church's teaching. One is a new exegesis of sacred Scripture which claims variously that Scripture has nothing to say on the subject of homosexuality, or that it somehow tacitly approves of it, or that all of its moral injunctions are so culture-bound that they are no longer applicable to contemporary life. These views are gravely erroneous and call for particular attention here.

5.) It is quite true that the biblical literature owes to the different epochs in which it was written a good deal of its varied patterns of thought and expression (*Dei Verbum*, No. 12). The Church today addresses the Gospel to a world which differs in many ways from ancient days. But the world in which the New Testament was written was already quite diverse from the situation in which the sacred Scriptures of the Hebrew people had been written or compiled, for example.

What should be noticed is that, in the presence of such remarkable diversity, there is nevertheless a clear consistency within the Scriptures themselves on the moral issue of homosexual behavior. The Church's doctrine regarding this issue is thus based, not on isolated phrases for facile theological argument, but on the solid foundation of a constant biblical testimony. The community of faith today, in unbroken continuity with the Jewish and Christian communities within which the ancient Scriptures were written, continues to be

Statement by Archbishop Hickey on Vatican document

Archbishop James A. Hickey issued the following statement in conjunction with the letter released by the Vatican last week on the Church's teaching on homosexuality.

I welcome the opportunity to introduce the newly issued letter of the Congregation for the Doctrine of the Faith on the Pastoral Care of Homosexual Persons. It is a very helpful guide for all who are involved in pastoral work with homosexual men and women. The letter is a clear, balanced and compassionate presentation of the Church's teaching.

Unfortunately some press accounts (published before the full text became available) distorted the spirit and content of the letter. That is why I decided to publish the full text in this issue of the *Catholic Standard*. Everyone has a right to know what the letter actually says; I urge you to read and study it with an open mind and heart. I want to highlight some of its important elements.

First we should remember that the new letter continues the constant teaching of the Church on the meaning and right use of our sexuality. It clarifies and expands the teaching on homosexuality found in the 1975 *Declaration on Sexual Ethics*.

CENTRAL TO that teaching is the distinction between a homosexual orientation and homosexual activity. It is only in the marriage of a man and a woman that the use of one's sexual faculty can be good. The marital relationship should be both loving and open to new life. By its nature, homosexual activity is not the complementary, life-giving union the Creator intended. That is why such activity is always wrong; it can never be condoned.

The letter also describes the homosexual orientation as flawed. Of itself this orientation or tendency is not sinful, but it can lead to what is sinful. The CDF does not condemn homosexual persons nor does it deny their God-given worth and dignity. We must remember that everyone has tendencies toward sinful behavior and everyone needs the Lord's grace to resist them. Many people with a homosexual orientation lead good, productive and faithful lives. They deserve our support and effective pastoral care. Others who have not yet been able to accept the Lord's invitation have a special claim on our pastoral concern.

PASTORAL CARE for homosexual men and women must be based on a strong trust in the victory of Christ over sin, the power of the sacraments to transform our lives and the mercy the Lord offers us. Moreover, such pastoral care must be carried out in accordance with the Church's teaching on the purposes of human sexuality, the centrality of the family and the great worth of each person. Through the sacrament of Penance and the Eucharist, homosexual persons should be supported in their efforts to lead chaste and holy lives, and thus to develop fully their human potential. We must also work to overcome prejudice against homosexual persons without approving homosexual activity.

Every person in the Church deserves pastoral care that is based on both truth and compassion. The two are not opposed but linked. Compassion is not genuine unless it is truthful and the truth must always be presented with compassion. The pastoral care of homosexual men and women is no exception. The task at hand is to speak the truth in love.

nourished by those same Scriptures and by the spirit of truth whose word they are. It is likewise essential to recognize that the Scriptures are not properly understood when they are interpreted in a way which contradicts the Church's living tradition. To be correct, the interpretation of Scripture must be in substantial accord with that tradition.

THE VATICAN COUNCIL II in *Dei Verbum*, No. 10, put it this way: "It is clear, therefore, that in the supremely wise arrangement of God, sacred tradition, sacred Scripture and the magisterium of the Church are so connected and associated that one of them cannot stand without the others. Working together, each in its own way under the action of the one Holy Spirit, they all contribute effectively to the salvation of souls." In that spirit we wish to outline briefly the biblical teaching here.

6.) Providing a basic plan for understanding this entire discussion of homosexuality is the theology of creation we find in Genesis. God, by His infinite wisdom and love, brings into existence all of reality as a reflection of His goodness. He fashions mankind, male and

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female, in His own image and likeness. Human beings, therefore, are nothing less than the work of God Himself, and in the complementarity of the sexes, they are called to reflect the inner unity of the Creator. They do this in a striking way in their cooperation with Him in the transmission of life by a mutual donation of the self to the other.

In Genesis 3, we find that this truth about persons being an image of God has been obscured by original sin. There inevitably follows a loss of awareness of the covenantal character of the union these persons had with God and with each other. The human body retains its "spousal significance" but this is now clouded by sin. Thus, in Genesis 19:1-11, the deterioration due to sin continues in the story of the men of Sodom. There can be no doubt of the moral judgment made there against homosexual relations. In Leviticus 18:22 and 20:13, in the course of describing the conditions necessary for belonging to the chosen people, the author excludes from the people of God those who behave in a homosexual fashion.

AGAINST THE BACKGROUND of this exposition of theocratic law, an eschatological perspective is developed by St. Paul when, in I Corinthians 6:9, he proposes the same doctrine and lists those who behave in a homosexual fashion among those who shall not enter the kingdom of God.

In Romans 1:18-32, still building on the moral traditions of his forebears, but in the new context of the confrontation between Christianity and the pagan society of his day, Paul uses homosexual behavior as an example of the blindness which has overcome humankind. Instead of the original harmony between Creator and creatures, the acute distortion of idolatry has led to all kinds of moral excess. Paul is at a loss to find a clearer example of this disharmony than homosexual relations. Finally, I Timothy 1, In full continuity with the biblical position, singles out those who spread wrong doctrine and in verse 10 explicitly names as sinners those who engage in homosexual acts.

7.) **THE CHURCH**, obedient to the Lord who founded her and gave to her the sacramental life, celebrates the divine plan of the loving and life-giving union of men and women in the sacrament of marriage. It is only in the marital relationship that the use of the sexual faculty can be morally good. A person engaging in homosexual behavior therefore acts immorally.

To choose someone of the same sex for one's sexual activity is to annul the rich symbolism and meaning, not to mention the goals, of the Creator's sexual design. Homosexual activity is not a complementary union, able to transmit life, and so it thwarts the call to a life of that form of self-giving which the Gospel says is the essence of Christian living. This does not mean that homosexual persons are not often generous and giving of themselves, but when they engage in homosexual activity they confirm within themselves a disordered sexual inclination which is essentially self-indulgent.

As in every moral disorder, homosexual activity prevents one's own fulfillment and happiness by acting contrary to the creative wisdom of God. The Church, in rejecting erroneous opinions regarding homosexuality, does not limit but rather defends personal freedom and dignity realistically and authentically understood.

8.) **THUS, THE CHURCH'S** teaching today is in organic continuity with the scriptural perspective and with her own constant tradition. Though today's world is in many ways quite new, the Christian community senses the profound and lasting bonds which join us to those generations who have gone before us, "marked with the sign of faith."

Nevertheless, increasing numbers of people today, even within the Church, are bringing enormous pressure to bear on the Church to accept the homosexual condition as though it were not disordered and to condone homosexual activity. Those within the Church who argue in this fashion often have close ties with those with similar views outside it. These latter groups are guided by a vision opposed to the **truth about the human person, which is fully disclosed in the mystery of Christ. They reflect,** even if not entirely consciously, a materialistic ideology which denies the transcendent nature of the human person as well as the supernatural vocation of every individual.

The Church's ministers must ensure that homosexual persons in their care will not be misled by this point of view, so profoundly opposed to the teaching of the Church. But the risk is great and there are many who seek to create confusion regarding the Church's position, and then to use that confusion to their own advantage.

9.) **THE MOVEMENT** within the Church, which takes the form of pressure groups of various names and sizes, attempts to give the impression that it represents all homosexual

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persons who are Catholics. As a matter of fact, its membership is by and large restricted to those who either ignore the teaching of the Church or seek somehow to undermine it. It brings together under the aegis of Catholicism homosexual persons who have no intention of abandoning their homosexual behavior. One tactic used is to protest that any and all criticism of or reservations about homosexual people, their activity and lifestyle, are simply diverse forms of unjust discrimination.

There is an effort in some countries to manipulate the Church by gaining the often well-intentioned support of her pastors with a view to changing civil statutes and laws. This is done in order to conform to these pressure groups' concept that homosexuality is at least a completely harmless, if not an entirely good, thing. Even when the practice of homosexuality may seriously threaten the lives and well-being of a large number of people, its advocates remain undeterred and refuse to consider the magnitude of the risks involved.

The Church can never be so callous. It is true that her clear position cannot be revised by pressure from civil legislation or the trend of the moment. But she is really concerned about the many who are not represented by the pro-homosexual movement and about those who may have been tempted to believe its deceitful propaganda. She is also aware that the view that homosexual activity is equivalent to, or as acceptable as, the sexual expression of conjug love has a direct impact on society's understanding of the nature and rights of the family and puts them in jeopardy.

10.) **IT IS DEPLORABLE** that homosexual persons have been and are the object of violer

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malice in speech or in action. Such treatment deserves condemnation from the Church's pastors wherever it occurs. It reveals a kind of disregard for others which endangers the most fundamental principles of a healthy society. The intrinsic dignity of each person must always be respected in word, in action and in law.

But the proper reaction to crimes committed against homosexual persons should not be to claim that the homosexual condition is not disordered. When such a claim is made and when homosexual activity is consequently condoned, or when civil legislation is introduced to protect behavior to which no one has any conceivable right, neither the Church nor society at large should be surprised when other distorted notions and practices gain ground, and irrational and violent reactions increase.

11.) It has been argued that the homosexual orientation in certain cases is not the result of deliberate choice, and so the homosexual person would then have no choice but to behave in a homosexual fashion. Lacking freedom, such a person, even if engaged in homosexual activity, would not be culpable.

Here, the Church's wise moral tradition is necessary since it warns against generalizations in judging individual cases. In fact, circumstances may exist, or may have existed in the past, which would reduce or remove the culpability of the individual in a given instance, or other circumstances may increase it. What is at all costs to be avoided is the unfounded and demeaning assumption that the sexual behavior of homosexual persons is always and totally compulsive and therefore inculpable. What is essential is that the fundamental liberty which characterizes the human person and gives him his dignity be recognized as belonging to the homosexual person as well. As in every conversion from evil, the abandonment of homosexual activity will require a profound collaboration of the individual with God's liberating grace.

12.) **WHAT, THEN**, are homosexual persons to do who seek to follow the Lord? Fundamentall they are called to enact the will of God in their life by joining whatever sufferings and difficul

ties they experience in virtue of their condition to the sacrifice of the Lord's cross. That cross, for the believer, is a fruitful sacrifice since from that death come life and redemption. While any call to carry the cross or to understand a Christian's suffering in this way will predictably be met with bitter ridicule by some, it should be remembered that this is the way to eternal life for all who follow Christ.

It is, in effect, none other than the teaching of Paul the Apostle to the Galatians when he says that the Spirit produces in the lives of the faithful "love, joy, peace, patience, kindness, goodness, trustfulness, gentleness and self control" (5:22) and further (verse 24), "You cannot belong to Christ unless you crucify all self-indulgent passions and desires."

It is easily misunderstood, however, if it is merely seen as a pointless effort at self-denial. The cross is a denial of self, but in service to the will of God Himself who makes life come from death and empowers those who trust in Him to practice virtue in place of vice.

TO CELEBRATE the paschal mystery, it is necessary to let that mystery become imprinted in the fabric of daily life. To refuse to sacrifice one's own will in obedience to the will of the Lord is effectively to prevent salvation. Just as the cross was central to the expression of God's redemptive love for us in Jesus, so the conformity of the self-denial of homosexual men and women with the sacrifice of the Lord will constitute for them a source of self-giving which will save them from a way of life which constantly threatens to destroy them.

Christians who are homosexual are called, as all of us are, to a chaste life. As they dedicate their lives to understanding the nature of God's personal call to them, they will be able to celebrate the sacrament of penance more faithfully and receive the Lord's grace so freely offered there in order to convert their lives more fully to His way.

13.) We recognize, of course, that in great measure the clear and successful communication of the Church's teaching to all the faithful, and to society at large, depends on the correct instruction and fidelity of her pastoral ministers. The bishops have the particularly grave responsibility to see to it that their assistants in the ministry, above all the priests, are rightly informed and personally disposed to bring the teaching of the Church in its integrity to everyone.

The characteristic concern and good will exhibited by many clergy and religious in their pastoral care for homosexual persons is admirable, and, we hope, will not diminish. Such devoted ministers should have the confidence that they are faithfully following the will of the Lord by encouraging the homosexual person to

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lead a chaste life and by affirming that person's God-given dignity and worth.

14.) **WITH THIS IN MIND**, this congregation wishes to ask the bishops to be especially cautious of any programs which may seek to pressure the Church to change her teaching, even while claiming not to do so. A careful examination of their public statements and the activities they promote reveals a studied ambiguity by which they attempt to mislead the pastors and the faithful. For example, they may present the teaching of the magisterium, but only as if it were an optional source for the formation of one's conscience. Its specific authority is not recognized. Some of these groups will use the word "Catholic" to describe either the organization or its intended members, yet they do not defend and promote the teaching of the magisterium, indeed, they even openly attack it. While their members may claim a desire to conform their lives to the teaching of Jesus, in fact they abandon the teaching of His Church. This contradictory action should not have the support of the bishops in any way.

15.) We encourage the bishops, then, to provide pastoral care in full accord with the teaching of the Church for homosexual persons of their dioceses. No authentic pastoral program will include organizations in which homosexual persons associate with each other without clearly stating that homosexual activity is immoral. A truly pastoral approach will

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appreciate the need for homosexual persons to avoid the near occasions of sin.

We would heartily encourage programs where these dangers are avoided. But we wish to make it clear that departure from the Church's teaching, or silence about it, in an effort to provide pastoral care is neither caring nor pastoral. Only what is true can ultimately be pastoral. The neglect of the Church's position prevents homosexual men and women from receiving the care they need and deserve.

An authentic pastoral program will assist homosexual persons at all levels of the spiritual life: through the sacraments, and in particular through the frequent and sincere use of the sacrament of reconciliation, through prayer, witness, counsel and individual care. In such a way, the entire Christian community can come to recognize its own call to assist its brothers and sisters, without deluding them or isolating them.

16.) **FROM THIS** multifaceted approach there are numerous advantages to be gained, not the least of which is the realization that a homosexual person, as every human being, deeply needs to be nourished at many different levels simultaneously.

The human person, made in the image and likeness of God, can hardly be adequately described by a reductionist reference to his or her sexual orientation. Everyone living on the face of the earth has personal problems and difficulties, but challenges to growth, strengths, talents and gifts as well. Today, the Church provides a badly needed context for the care of the human person when she refuses to consider the person as a "heterosexual" or a "homosexual" and insists that every person has a fundamental identity: the creature of God, and by grace, his child and heir to eternal life.

17.) In bringing this entire matter to the bishops' attention, this congregation wishes to support their efforts to assure that the teaching of the Lord and his Church on this important question be communicated fully to the faithful.

IN LIGHT of the points made above, they should decide for their own dioceses the extent to which an intervention on their part is indicated. In addition, should they consider it helpful, further coordinated action at the level of their national bishops' conference may be envisioned.

In a particular way, we would ask the bishops to support, with the means at their disposal, the development of appropriate forms of pastoral care for homosexual persons. These would include the assistance of the psychological, sociological and medical sciences, in full accord with the teaching of the Church.

They are encouraged to call on the assistance of all Catholic theologians who, by teaching what the Church teaches, and by deepening their reflections on the true meaning of human sexuality and Christian marriage with the virtues it engenders, will make an important contribution in this particular area of pastoral care.

THE BISHOPS ARE ASKED to exercise special care in the selection of pastoral ministers so that by their own high degree of spiritual and personal maturity and by their fidelity to the magisterium they may be of real service to homosexual persons, promoting their health and well-being in the fullest sense. Such ministers will reject theological opinions which dissent from the teaching of the Church and which, therefore, cannot be used as guidelines for pastoral care.

We encourage the bishops to promote appropriate catechetical programs based on the truth about human sexuality in its relationship to the family as taught by the Church. Such programs should provide a good context within which to deal with the question of homosexuality.

This catechesis would also assist those families of homosexual persons to deal with this problem which affects them so deeply.

ALL SUPPORT should be withdrawn from any organizations which seek to undermine the teaching of the Church, which are ambiguous about it, or which neglect it entirely. Such support, or even the semblance of such support, can be gravely misinterpreted. Special attention

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should be given to the practice of scheduling religious services and to the use of church buildings by these groups, including the facilities of Catholic schools and colleges. To some, such permission to use church property may seem only just and charitable, but in reality it is contradictory to the purpose for which these institutions were founded, it is misleading and often scandalous.

In assessing proposed legislation, the bishops should keep as their uppermost concern the responsibility to defend and promote family life.

18.) The Lord Jesus promised, "You shall know the truth and the truth shall set you free" (Jn 8:32). Scripture bids us speak the truth in love (cf. Eph 4:15). The God who is at once truth and love calls the Church to minister to every man, woman and child with the pastoral solicitude of our compassionate Lord. It is in this spirit that we have addressed this letter to the bishops of the Church, with the hope that it will be of some help as they care for those whose suffering can only be intensified by error and lightened by truth.

During an audience granted to the undersigned prefect, his holiness, Pope John Paul II, approved this letter, adopted in an ordinary session of the Congregation for the Doctrine of the Faith, and ordered it to be published.

Given at Rome, Oct. 1, 1986.

Cardinal Joseph Ratzinger, prefect.
Archbishop Alberto Bovone, secretar

Planned Parenthood®
of Central South Carolina, Inc.

December, 1986

"We warn our children early about the dangerous consequences of playing with matches or crossing the street before checking for traffic. We have no less a responsibility to guide them in avoiding behaviors that may expose them to AIDS ... "

> Surgeon General C. Everett Koop in statements made upon the release of his report on AIDS. He went on to add that we should begin teaching children about the disease "at the lowest grade possible."
>
> Newsweek, November 3, 1986

Dear Friend:

AT LAST! Even the Surgeon General has conceded that sex education is needed !

Planned Parenthood has always thought it incredible that schools have too often seen knowledge as an essential thing in every area but sexuality. As you may know, the cornerstone of our work has always been in education and counseling. We have always talked openly about sexually transmitted diseases. We have led the way in open communication about sexuality between parents and children, while always believing that parents and children must talk with trust in order for children to develop responsible and moral attitudes. Our mother-daughter seminars have been particularly effective.

The irony is that funding for educational programs is not readily available -- in spite of public support for sex education and in spite of the fact that preventive programs such as education help forestall more substantial spending of our tax dollars on social welfare programs.

At Planned Parenthood we don't charge for our educational programs (except occasionally for the cost of materials.) While our medical services generally pay for themselves, we don't ask schools, colleges, churches, pre-release prisoners and others in the community to pay for our presentations.

That is why we are turning to intelligent citizens like you. We know that you want us to continue to lead the way in sex education and counseling in this frightening time when we're faced with an alarming teenage pregnancy rate, the spread of more strains of sexually transmitted diseases and the crisis of AIDS.

2712 Middleburg Drive, Suite 106 Columbia, South Carolina 29204 (803) 256-4908

Your contribution will mean a difference in the number of people we can reach and serve in our educational and counseling programs in 1987. And, of course, there are some important financial reasons for you to give generously before the new tax law goes into effect:

... your tax-deductible gift to Planned Parenthood may be more beneficial to you now in reducing your taxable income than in 1987 when tax rates will be lower.

... 1986 is the last year you may file a non-itemized tax return and still deduct your gift to Planned Parenthood from your total income.

... A gift of property that has increased in value since you acquired it (such as stocks) may entitle you to a much greater tax deduction now than after January 1.

Won't you join thousands of others who believe that the educational work and leadership of Planned Parenthood is essential to our lives in the Midlands of South Carolina?

So please care. And please help. We hope you'll give as much as you can.

Gratefully,

R Sargent

Roger Sargent
President

P.S. We receive no government or United Way funding so your gift is especially needed and appreciated.

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2712 Middleburg Drive, Suite 106
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WHO JUST JOINED OUR FIGHT FOR SEX EDUCATION?

FOR A
PRO-LIFE
SOLUTION TO THE
ABORTION PROBLEM

Christian Action Council

701 W. Broad St., Suite 405 • Falls Church, VA 22046
(703) 237-2100

January 15, 1987

James O. Mason, M.D., Dr.P.H.
Assistant Surgeon General
Director
Centers for Disease Control
Atlanta, GA 30333

Dear Dr. Mason,

Thank you for your prompt response to my recent letter regarding the need for a timely, objective study on abortion morbidity.

I appreciate very much your statement that your decision to pursue a mortality study "was not to the exclusion of abortion-related morbidity."

I also am grateful for your subsequent decision to conduct a case-control study examining potential causes of ectopic pregnancy, including abortion and PID. As you point out, ectopic pregnancy is one example of abortion morbidity.

An unbiased, prospective, longitudinal study on abortion morbidity, broadly speaking, would undoubtedly also be of great value. However, there are two concerns that I must raise as you study the feasibility of such research.

Chief among these is the issue of timing. A valid prospective study would probably take at least five to seven years to complete. This is particularly the case if abortion morbidity is understood to include adverse psychological consequences attended by physical effects (e.g. increased use of alcohol and drugs, suicide ideation, sexual dysfunction, and psychosomatic problems, such as anorexia, bulimia, cervical pain in intercourse).

This multi-year period must be added to whatever time elapses to complete the present feasibility study and, if all proceeds satisfactorily, the organization of the research project and the considerable funds necessary to complete it.

Given the "pro-choice" bias within the Government's health bureaucracy and the changing of administrations (and priorities) in two years, the chances of a prospective study surviving uncorrupted seven or more years, let alone being completed, is unlikely.

The second issue I must raise is the need for a more timely assessment of abortion morbidity. Dr. David Reardon, Dr. Anne

Speckhard, and Dr. Terry Selby are three therapists who report that among their patients experiencing Post Abortion Stress Syndrome, they find a high incidence of abortion morbidity. If you have read the testimonies and stories of women involved in organizations such as Women Exploited by Abortion, Open Arms, and Victims of Choice, you must be appalled as I am at the injurious physical consequences among many post abortive women.

Please correct me if I am wrong, but is it not true that public health threats generally appear initially through clinical observation and anecdote, meriting formal investigation? An inexplicable gap now exists between most studies of abortion morbidity and reports from women who have undergone abortion. From my reading of the studies, I can argue forcefully that personal biases on abortion have colored perceptions at both ends of this gap.

A cross sectional, retrospective study could determine within fifteen months the incidence of abortion-related morbidity and whether a far more expensive and time consuming prospective, longitudinal study is in order. Such support for a longitudinal study may become necessary in any event.

What troubles me most about your letter is that it does not engage the possibility of doing a retrospective study. While a prospecitive study would eventually be more thorough, a retrospective study not only is more timely but, for reasons I have outlined, more feasible as a practical matter.

I would appreciate very much if you could provide me with your perspective on a retrospective study of abortion morbidity and whether it seems to you a prudent course of action.

Sincerely,

Curtis J. Young
Executive Director

THE WHITE HOUSE

WASHINGTON

January 8, 1987

MEMORANDUM FOR

FROM:

SUBJECT: AIDS

Issue: What further steps should be taken to prevent the spread of AIDS in America?

Background: The first known report of the AIDS virus was reported in May 1982 by the Center for Disease Control. The disease was identified in homosexual males and cases were reported by physicians in several major metropolitan areas in the United States.

The Center for Disease Control estimates that there are 1.5 million Americans who now carry the virus but display no symptoms. Other estimates range as high as 4 million carriers of the virus. No one knows for sure.

Official projection for the next five years are that 179,000 will die of the AIDS epidemic. These figures are based on the assumption that only those Americans presently infected will get AIDS by 1991.

More than 90 percent of victims of AIDS are from two main risk groups, male homosexuals and intravenous drug users. Heterosexual cases come primarily through prostitutes and their clients. However, by 1991, there will also be more than 3000 newborn infants with AIDS who will lead short, painful lives. Some individuals will contract AIDS through contaminated blood and a growing percentage of victims are getting AIDS from unknown sources.

Dr. William A. Haseltine, a leading AIDS researcher at the Harvard Medical School in Boston warns that, "the AIDS epidemic will produce an enormous and frightening effect on world health that public health officials may be relatively powerless to contain. We must be prepared to anticipate that the vast majority of those now infected will ultimately, over a period of five to ten years, develop life-threatening illness."

Up to ten million people worldwide now carry the AIDS virus and are potential victims. About 80 nations have reported cases. In Great Britain, the incidence of AIDS is doubling every year. In Africa, 50,000 people have died since the first appearance of AIDS in the late 70's, although the World Health Organization estimates that several hundred thousand have died and that as many as 5 million Africans now carry the virus.

As far as we know now, AIDS is always fatal. If a cure cannot be found soon -- and chances appear to be slim that one is imminent -- the death toll could be enormous.

Discussion: Since the AIDS virus has been identified, millions of dollars have been poured into research worldwide in order to try and find a cure for the disease. The 1987 Federal budget includes $534 million for AIDS research and education. The medical concensus is that a means for arresting AIDS will come no sooner than five to ten years from now. Finding a cure is difficult because there are already three similar viruses that cause AIDS and the virus mutates frequently.

The Health Policy Working Group has reported three times to the Domestic Policy Council, including once to the President, and the Council approved the following policy statements:

- deal with AIDS as a major public health threat;
- mount a major effort that would focus on prevention and dissemination of information on AIDS;
- encourage Federal agencies and State and local authorities to take all necessary steps to lessen the risk of the spread of the AIDS infection.

In his 1986 State of the Union Message, the President asked the Surgeon General to prepare a report to the American people on AIDS. That report was developed and submitted to the Council in October 1986. It has been widely distributed by HHS and other Federal agencies as well as private groups.

Dr. Windom, Assistant Secretary for Health, established an AIDS coordinating Council headed by Dr. Gary Noble that has met several times since October 1986 and is developing an information/education plan to prevent and control AIDS in the United States. As a result of the national debate that has been stirred by the Surgeon General's Report on AIDS and the discussion in the Federal Coordinating Council on AIDS, several policy issues have surfaced. Some of these issues are listed below.

Policy Issues

1. Is AIDS covered by the Control of Communicable Disease Act? (Sec. 264)

2. Should contact tracing of individuals with AIDS and carriers of the AIDS virus be conducted as is currently the case with other veneral diseases?

3. Should all carriers of AIDS be reported to public health officials and confidential records kept as is currently the case with other veneral diseases?

4. Should the blood supply be better protected by making it illegal for "at risk" persons to donate blood?

5. Should blood testing for AIDS and the AIDS antibody be required before a marriage license is issued?

6. Should a Federal order be issued closing down all known homosexual bath houses?

7. Should policy statements issued by HHS or other Federal agencies on sex education include the following concepts:

   - o instruction in sound healthful principles of sexual conduct;
   - o encouraging individuals to refrain from sexual intercourse outside of marriage;
   - o information on the grevious medical, personal, and social consequences of sexual promiscuity;
   - o a statement that homosexuality is an unhealthy, unsafe, and lethal sexual alternative;
   - o that condom use, while decreasing the risk of contracting AIDS, is not 100% safe, since there is at least a 10% failure rate in preventing conception.
   - o encourage chastity before and fidelity after marriage as the only 100% safe way of avoiding AIDS.

8. How will the health care system deal with the increased cost of caring for AIDS victims over the next decade and beyond?

AASECT NEWSLETTER

VOL. 17 NOVEMBER 1986

American Association of Sex Educators, Counselors and Therapists

"The Power of Sex" is XX Annual Meeting Theme

The XX Annual Meeting, "The Power of Sex In Our Everyday Lives," will be held in New York April 30–May 3, 1987.

"This multidisciplinary conference will demonstrate how a healthy and productive use of the power of sex can improve the quality of our lives, our relationships, and our society," said Theresa L. Crenshaw, M.D., President of AASECT.

The Annual Meeting will be held in the New York Marriott Marquis, the newest luxury convention hotel in the city. Room rates at the Marriott Marquis start at $200.00, but a special rate has been made available for Annual Meeting attendees. Single and double rooms for the conference will be $120.00. To facilitate even greater savings, a room-sharing plan is available. Just indicate on the reservation form an interest in sharing a room. A list of all members interested in room sharing will be compiled and sent to interested registrants who can contact each other for room-sharing arrangements. The price of a room then becomes only $60.00 a night each. This plan is open to AASECT members only.

The Marriott Marquis is located in the heart of midtown Manhattan on Broadway between 45th and 46th streets. Shows, shopping and tours are just steps away from the hotel.

The program will deal with the power of sex in health, disease, psychology, behavior, crime, politics, law, art, science, religion, business, war and peace. "The ethical practice of therapy and education requires a sophisticated understanding of the many unrecognized positive and negative realities of human sexuality," Dr. Crenshaw said.

"We will show how to influence the politics of sex underlying many of the key controversies facing society today—sex education, abortion, AIDS, and pornography," she said. This conference will provide training in human sexuality essential to the competent practice of medicine, psychotherapy, marriage and family counseling, education, the law, and religion," Dr. Crenshaw said.

(See *Annual Meeting* page 13)

AASECT to Certify Supervisors

Members of AASECT who have been Certified Sex Therapists for at least five years are eligible to apply for new certification category—Certified Supervisor.

Certified Sex Therapists received notification of the new category by a special mailing in August. Applications for the Certified Supervisor designation are being accepted under grandparent requirements for one year. The grandparent year ends August 31, 1987.

Application for the grandparent year program involves several different requirements. First, applicants must have held the designation of Certified Sex Therapist for a minimum of five years when the supervisor application is received in the National Office. The applicant must also be able to show evidence of participation in the field of sexuality, especially in the diagnosis and treatment of sexual dysfunction.

(See *Supervisors* page 11)

SPECIAL CENTER SECTION

A special center section has been included to show some of the highlights of the 1987 Annual Meeting. A registration form is included. Register now to receive special Early Bird rates for members.

Note the wide variety of pre-conference workshops available. Glance over the list of speakers scheduled for the Annual Meeting. Don't miss the center section, "The Power of Sex."

ASSECT Newsletter

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AASECT National Office

From the Executive Director

Next year will mark the twentieth anniversary of the beginning of what has become the American Association of Sex Educators, Counselors and Therapists. Originally it was called the American Association of Sex Educators and Counselors. Then, meeting the public's expressed need for treatment, it added therapists to both its membership and name.

Such changes are significant to the life of the Association. They, like the organization itself, have been made to meet the needs of the public for practitioners and educators in sexology. That is what AASECT is about. It is an organization of practitioners in the field of sexology. It is unique as such.

Certainly, AASECT and its members have always been interested in advocacy and in research. But its focus, as its name explains, has been on practice, on meeting the needs of the public. When it first began, practice in the field of sexology was often viewed as not "respectable." Now it has become a fast growing speciality. The problem of respectability, however, is still there but in another guise.

Persons who have little or no education or training in the field have advertised themselves as sex therapists. And they are not only doing harm because of their lack of knowledge, but also because of their lack of ethics. Almost every week there comes across the desk of the Executive Director a request from some law enforcement agency, a request for the AASECT standards and *Code of Ethics* to be used as a basis of what constitutes acceptable practice.

That there are written standards and a *Code of Ethics* speaks again to the response to change and need that AASECT has given. Long before accreditation became a popular way for so many groups to show their professionalism, AASECT began its certification programs. Throughout the years, the vast majority of members submitted their credentials and their professional conduct to the scrutiny of peers, even though the certification they sought would not necessarily enhance their economic status nor professional standing. They did it because they believed in maintaining standards of practice for the protection of the public.

This fact has amazed many of those who seek information, such as law-enforcement agencies and journalists. It has legitimized the field as far as they are concerned. That is a lot to be able to say of the work of an organization that is only twenty years old. There will be even more to say of it after another twenty years has passed, for AASECT continues to be paramount in the practice of sexology and to maintain its vigil for the public welfare.

Registration Fee Rebate Offered to Student Volunteers

This year AASECT will be offering student members the opportunity to work at the Annual Meeting. Student members are needed to assist in major areas of the New York City meeting, including Registration, Press Room, Job Search, Message Board, Exhibits, and the AASECT Information Booth. Students will be reimbursed full registration for one day of work (approximately 8 hours).

Interested students must register now for the meeting. The registration fee will be retained until after the meeting when reimbursements will be made. Students coming to the meeting and interested in working should contact

Dr. Sandra Caron
Peer Sexuality Program
202 Steele Hall
Syracuse University
Syracuse, New York 13244-1120
(315) 423-3637

To be considered for this work, students should respond no later than March 1, 1987.

Educator Consortium to Meet in New York City

The Consortium of Sex Educators in the Health Professions will have an afternoon program on Wednesday, April 29, 1987 at the Marriot Marquis Hotel in New York City.

The program, scheduled during the pre-conference workshops, will present alternate approaches to sexual education as well as new trends in education. There will also be an opportunity for open dialogue to share concerns. The program is invitational.

For more information contact

Sandra Cole
Department of PM & R
University of Michigan Hospitals
1H2210050
1500 East Medical Center Drive
Ann Arbor, MI 48109-0050
(313) 936-7067

Workshops

Workshops and Training Programs

Three kinds of **"Sexual Attitude Reassessment Seminars (SARS)"** will be held at the University of Minnesota during the 1986–1987 Calendar year. "General SARS" will be held November 13–14, 1986, January 16–17, 1987, March 6–7, 1986 and June 12–13, 1987. A Same Sex Seminar "On Being Different" will be held April 10–11, 1987 and a "Family Sex Education Seminar" will be held October 25–26, 1986.

For more information, contact SAR Coordinator, Program in Human Sexuality Department of Family Practice and Community Health, University of Minnesota, Minneapolis, MN 54414 (612) 376-7520.

"Third Conference on Communication Therapy." March 26–28, 1987 in Chicago, IL. The conference will offer theoretical and experiental sessions on the role and scope of intrapersonal, interpersonal, intercultural and transpersonal communication in the therapeutic process. Proposals for theoretical papers, scholarly symposia, experiential workshops and training sessions are invited for presentation. A one-day training institute on various aspects of communication therapy will precede the conference. For more information, contact Dr. Tulsi Saral, Professor of Behavioral Science, University of Houston, Clear Lake, Houston, TX 77058 (713) 488-9310.

"New National Training Institute," providing two-day training workshops in subject areas related to adolescent sexuality, reproductive health, and family planning to be held in Boston, MA, November 5–6, 1986; Birmingham, AL, November 17–20, 1986; Indianapolis, IN, February 3–4, 1987, San Francisco, CA, February 19–20, 1987, and Seattle, WA, March 2–3, 1987.

For more information, contact the National Training Institute, Center for Population Options, 1012 14th Street, N.W., Suite 1200, Washington, D.C. 20005 (202) 347-5700.

"The Challenge of AIDS: Sharing Strategies and Solutions," is the title of a conference to be held November 12–14, 1986 in Miami, FL. The conference will offer workshops in the areas of "Care and Treatment," "Education and Information," "Research and Prevention," and "Legal and Ethical Issues."

For more information, contact Peter Myer, Conference Coordinator, Miami-Dade Community College/ Wolfson Campus, Room 2201, 300 N.E. 2nd Avneue, Miami, FL 33132 (305) 347-3251.

(See *Workshops* page 11)

GOALS OF THIS PRESIDENT
A Retrospective Look

By Theresa L. Crenshaw, M.D.

AASECT is emerging from chaos to stability, and from survival to progress. Observing and experiencing the work of the July Board meeting, it became very clear to me that the boards of the last two to three years have been very effective and accomplished an enormous amount. They may have done it the hard way, without an Executive Director for long periods, they may have been occasionally and perhaps even perpetually disorganized with the relocation of the National Office from one place to another, but they got the job done in spite of what would, by some, be considered insurmountable obstacles.

We have completed our guidelines for certification for educators, counselors, and therapists, we have guidelines for supervision completed as of this month, and are in fact, currently accepting applications for supervisors. We have the beginnings of a continuing education division, a program committee for our Annual Meeting that is 80% through with their gargantuan task, and our next program chair already in place, beginning work on 1988.

If we are going to look back, let's look back accurately. Our past has been frustrating, inefficient, sometimes chaotic but, nonetheless, productive. The future looks fantastic. My experience with this first Board meeting makes abundantly clear that we have no passengers on this journey. This administration will be remembered as one with "no excuses" and great accomplishments. AASECT has strength but we need more—the power of our Board, of our districts, and of our grass roots. The Board of AASECT needs to mature from a glorified committee and learn to function as a directorship.

When I began the Board meeting I thought we were like the phoenix rising from the flames. Now we need to set our flight plan, choose our destination, and get there.

A Prospective Look

I am going to go on record, setting my numerous goals for my brief year as president. The ones we accomplish, we can be proud of—the ones we don't, we will definitely get a good, firm start on for future administrations to follow through.

I have five major goals.

(1) The first is to make AASECT the most significant organization in America—a household word. You immediately recognize the National Rifle Association, the American Civil Liberties Union, Planned Parenthood, the AMA and the American Bar Association. You may not like them or you may think they're wonderful but you certainly know what those organizations stand for. We will raise AASECT to that stature and very possibly beyond. How? Through our relevance to current social needs. We will point out through our Annual Meeting, whose theme is the Power of Sex In Our Everyday Lives, how important sex, intimancy, love and relationships are to almost every aspect of living. Sex itself is going to come out of the closet and become known for what it really is—a wholesome, healthy, important part of life outside the bedroom—as well as behind closed doors.

(2) We are America's greatest resource as sex educators, counselors and therapists in protecting society by stopping the AIDS epidemic in its tracks. The AIDS epidemic is not inevitable. We can stem the tide through our ability to educate and alter the sexual behavior and practices of our society. This disease is not airborne—it is function of behavior. We have the power. We can make a difference—if we act now!

(3) We will strengthen AASECT by taking a strong ethical stand. Our ethics are excellent. We need to follow them, expand on them, stand by them, and educate the public that there are ethical, trustworthy, dependable sex educators, counselors and therapists.

(4) My next major goal is financial prosperity for AASECT. In the past, our Board and our organization have often had a break-even mentality. If we don't run AASECT as a responsible business we will be unable to grow and be unable to provide our membership with the service it expects. We will, of course, remain non-profit because we will spend on the membership the revenue we generate but we must generate revenue in order to serve our membership.

(5) My last major goal is professional excellence. I want AASECT to be the best. Our concept will be quality not quantity. Whether we are referring to sexual partners, orgasms or the educational programs we provide, the quality rather than the greater number will be the priority. Sex therapy and relationship therapy have never been more needed. Today, in the shadow of the radical right reactionary philosophy

(See *Goals* page 10)

AASECT Insurance Group Disability Plan Available to Members and Spouses

The Group Disability Income Insurance Plan now available to members and their spouses under age 60, provides $600 a month in tax-free disability benefits payable for up to one full year of continuous disability.

During the current enrollment period, which ends on December 1, 1986, members and spouses will be offered their first month of coverage for $1.00. After the first month for $1.00, premiums will be billed by mail twice a year at low group rates.

In addition to this dollar offer, normal eligibility requirements for coverage have been waived in favor of a more liberal acceptable policy—qualified applicants will be guaranteed acceptance. Members and/or their spouses who have been working full-time for the past 90 days and have not been hospitalized in the past six months qualify for this guaranteed acceptance until December 1, 1986.

Monthly benefits under this plan begin on the 31st day of disability and continue for up to one year for accident-related and sickness-related disabilities. All benefits are paid in addition to Social Security, Worker's Compensation and other disability payments received. The 30-day waiting period ties in with short-term payments provided through sick-leave or employer benefits while reducing the cost of the insurance.

AASECT has joined with several other organizations to co-sponsor this plan. By joining together, AASECT has increased its mass-buying power even more and can pass the savings along to members.

Members will be receiving complete details on the AASECT Group Disability Income Insurance Plan and the $1.00 enrollment offer through the mail this month. For more information, members can contact the AASECT Insurance Administrator: Albert H. Wohlers & Co.

AASECT GROUP INSURANCE PLANS
1500 Higgins Road, Park Ridge
Illinois 60068-5750
Call Toll-Free: 1-800-323-2106
Illinois Residents: 1-312-698-2221

Member News

Patricia Whelehan, Ph.D., CST has recently been promoted to associate professor of Anthropology and granted continuing appointment (tenure) at the State University College, Potsdam, New York. She is also a North Country referral person for the New York State Council on AIDS.

Isadora Alman, M.A. recently joined San Francisco, CA. radio station KGO. Ms. Alman, who had previously been a substitute host at the station is now hosting her own relationship oriented call-in program on Sunday evenings from 7–9 p.m. In addition to her radio program, Ms. Alman also conducts workshops in sexuality and social skills. Ms. Alman is also a columnist for the San Francisco Bay Guardian and a frequent lecturer at Bay area Colleges and Universities.

Winifred Kempton, M.S., CSE has received the Professional Service Award from the Coalition on Sexuality and Disability. The award was presented to Ms. Kempton in recognition of her pioneering work as an educator and advocate of the sexual rights of mentally retarded persons. For 30 years Kempton has worked with people with developmental disabilities.

Lauro S. Halstead, M.D., CSE has joined the new National Rehabilitation Hospital (NRH) in Washington, D.C. as director of the Post-Polio Program. He also assumes the position of interim director of the hospital's Spinal Cord Inquiry Program. Prior to joining NRH Dr. Halstead was medical director of the Post-Polio Program at the Institute for Rehabilitation and Research in Houston, Texas.

Dr. Halstead received his medical degree from the University of Rochester and his master's degree in public health from Harvard University. He was an associate professor of rehabilitation, community, and physical medicine at Baylor College of Medicine, Houston, Texas. He has conducted research, published numerous papers, and authored several books on a variety of subjects including the sexual consequences of physical disabilities.

Larry Hof, M.Div., SE, ST and **Joseph LoPiccolo, Ph.D., ST** will present a workshop at the American Association for Marriage and Family Therapy's annual conference in October. The workshop entitled Sexual Problems will address low sexual desire, "the number one sexual problem in the busy 80s" as well as a host of other sexual problems.

(See *Member News* page 13)

Newly Certified Members

The 13 members below were certified between July and November 1986 as AASECT-Certified Sex Educators, Sex Counselors, Sex Therapists, and Supervisors.

Certification is available to all members who meet the requirements approved by the Board of Directors which went into effect on July 1, 1985. Full Individual, Institutional, or Life Membership in AASECT is a prerequisite for making application in any or all categories of AASECT certification.

The requirements are availalbe from the National Office and will be sent on request. In order to apply for certification, application must be made on forms that reflect the new requirements. These forms are also available from the National Office.

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Pittsburgh, PA 15235

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Lushing, NY 11355

Jerome N. Sherman, Ph.D.
909 Frostwood, Suite 133
Houston, TX 77024

Dorothy Strauss, Ph.D.
1401 Ocean Avenue
Brooklyn, NY 11230

New Member Sponsors

From July 1, 1986 thru August 31, 1986

Below is a list of AASECT members who have sponsored new members since July 1, 1986. Board members have been especially active in promoting the activities of AASECT. They were responsible for 5 new members to the Association since July. There is a place on the membership application for a new member to fill in a sponsor. When distributing membership applications, encourage prospective members to fill in a sponsor. Sponsor information is important to the National Office.

Encourage new members to check the boxes on the Membership Application requesting information on the certification programs. Certification is one way AASECT can help maintain standards of practice for the protection of the public.

Three Members

Theresa L. Crenshaw, M.D.

One Member

Cheryl Gillespie, R.N., Ph.D.
Harvey Hester, Ed.D
Shirley Lampert
Robert J. Meyners, Ph.D.
Wallace Waldman

AIDS—MEETING THE CHALLENGE

by Theresa L. Crenshaw, M.D.

AASECT is critical to the control of the AIDS epidemic. The spread of AIDS can be prevented, but only through changing sexual behavior. AASECT can make the difference. We have educators at every level and can leverage the information we choose to disseminate to the elementary school level, high school, college and postgraduate as well as medical schools. We have therapists and counselors to whom individuals and couples in trouble will turn for help regarding their sexual and relationship concerns. These professionals can advise their patients on sexual behavior that will help to protect them from disease.

Basically, AASECT members are on the front line of the war against AIDS. Our responsibility is to respond in a responsible fashion. In 1985, the Western Regional AASECT Conference offered a workshop on AIDS which had to be cancelled due to lack of interest. In April 1986, at the AASECT National Conference in Los Angeles, the Saturday morning AIDS panel was relatively well attended. In 1987, we must encourage every AASECT member to educate themselves on the current state of information concerning AIDS so that they can share with their patients, clients and students everything that they need to know.

How can an AASECT member respond to these needs?

1. Don't be hysterical but *do* be concerned. You must be concerned enough to take action.
2. Become informed. Information is abundant in the scientific literature and in the lay press. Common sense can help you filter out fact from fiction and misinformation.
3. Be pro-active: educate your students about AIDS. Put it on your curriculum. You can't do too much. Advise your clients and patients wisely. Don't operate on wishful thinking and/or the ostrich approach.
4. Realize that hysteria is a natural and understandable response to an incurable fatal disease. Instead, engender concern and motivate your students, clients and patients to change their behavior from high risk to low risk, or no risk.
5. Learn from the gay experience with AIDS. Don't assume it can't happen to you. Take sensible precautions instead.
6. Recognize that high risk groups are simply a mathematical calculation of probabilities. If you have sex with someone who is infected, regardless of their label, you risk developing the disease.
7. Be aware that over the course of the last six years, almost all official figures have been underestimates in retrospect. The true extent of the epidemic is probably greater than current figures reflect.
8. Don't let wishful thinking, bias and politics skew the interpretation of the medical issues. Don't let reluctance to alter our sexual lifestyles alter the interpretation of scientific data instead.

What are today's facts?

- AIDS is not a homosexual disease.
- It does not require a compromised immune system, although, that certainly helps to increase the possibility of developing the disease.
- It does not require multiple exposures. The cases of HTLV III infection resulting from artificial insemination contradict these former conclusions. One exposure through artificial insemination during the absence of any bleeding in healthy women was sufficient to cause infection.
- While previously the antibody test was considered unreliable, current information suggests that both the Eliza and Western Blot when used together and interpreted correctly are quite definitive tests. Someone who has a confirmed positive antibody test to HTLV III is considered contagious.
- You have heard that the AIDS virus is difficult to get because of the relatively low concentrations of the virus in the vagina, blood and saliva; however, since the human being does not produce effective antibodies aginst AIDS, it may not require high concentrations to produce an infection.
- In the laboratory, condoms are effective against the passage of both the AIDS virus and sperm. However, condoms are not foolproof. In practice, condoms have a 10% failure rate for pregnancy, (per woman year) and since the AIDS virus is considerably smaller than a sperm, the failure rate is probably higher than 10%. Advise your clients to use condoms, but use their common sense as well.

There are many questions raised by the AIDS epidemic that affect your profession. I suggest that all of you ponder some of the challenging ones, such as: What are you going to tell your single patients? How

(See *AIDS* page 12)

Prometheus, the Greek god who stole fire from heaven and gave it to mankind, presides over Rockefeller Center's elegant Lower Plaza. The 18-foot high bronze statue, designed by Paul Manship, hovers over a cascading fountain which overlooks an ice rink in winter and outdoor eateries in summer. (Photo courtesy of the N.Y. Convention and Visitors Bureau.)

NEW YORK

The Empire State Building towers over its neighbors in midtown Manhattan in this aerial photo. To the north are the octagon-shaped Pan Am Building and the slender-spired Chrysler Building. The East River is visible at upper right. (Photo courtesy of the N.Y. Convention and Visitors Bureau.)

The Power of Sex

in health, disease, psychology, behavior, crime, politics, the law, art, religion, business, war, and peace.

Your EARLY BIRD Opportunity to be a Part of the Historic
AASECT XX ANNUAL MEETING

This multi-disciplinary conference will demonstrate how a healthy and productive use of the power of sex can improve the quality of our lives, our relationships, our society.

The ethical practice of sex therapy and education requires a sophisticated understanding of the many unrecognized positive and negative realities of human sexuality.

We will demonstrate how to identify and treat sexual problems as well as the abnormal psychosexual development that frequently leads to emotional disorders, crime, exploitation and aggression.

We will show how to influence the politics of sex underlying many of the key controversies facing society today—sex education, abortion, AIDS, and pornography.

This conference will provide training in human sexuality essential to the competent practice of medicine, psychotherapy, marriage and family counseling, education, the law, and religion.

Theresa L. Crenshaw, M.D.
President

In recognition of the significance of this special anniversary conference, many of the major leaders in the field of human sexuality have consented to teach special half-day pre-conference workshops. The caliber of this faculty means that space will go very quickly. We urge you to make your selection and register now—to avoid disappointment.

The Statute of Liberty raises her torch as welcome, as a Circle Line boat glides by in New York City harbor. Dominating the skyline of Lower Manhattan are the twin towers of the World Trade Center. In the distance at the left is the Empire State Building and, on the far right, the Brooklyn Bridge spanning the East River. (Photo courtesy of the N.Y. Convention and Visitors Bureau.)

PRE-CONFERENCE WORKSHOPS
AASECT XX ANNUAL MEETING
WEDNESDAY, APRIL 29, 1987

Morning Workshops—9:00 am to Noon

No. 1 ROBERT KOLODNY, M.D.
Evaluation and Treatment of Impotence—Psychotherapy Techniques

No. 2 LONNIE BARBACH, PH.D.
Becoming Orgasmic—Treatment Techniques

No. 3 PAUL FLEMING, M.D., D.H.S.
SAR Workshop—Twelve Full Hours—Sexual Attitude Restructuring—Part I

No. 4 ED BRECHER
Sex, Love, and Aging: Preservation Through Prevention

No. 5 MARY LEE TATUM, M.ED
Making Sex Education Work

No. 6 STEVEN ENGLEBERG, J.D.
Legalities—Knowing Your Rights, Liabilities and Responsibilities

No. 7 KAY FRANCES SCHEPP, ED.D.
Assessment and Treatment Planning in Sex Counseling

No. 8 MARTY WEISBURG, M.D.—BRUCE DAN, M.D.
Media Readiness for Sex Therapists, Counselors and Educators

Afternoon Workshops—2:00 to 5:00 pm

No. 9 BERNIE ZILBERGELD, PH.D.
ARNOLD LAZARUS, PH.D.
The Evaluation and Treatment of Premature Ejaculation and Inhibited Ejaculation Using Hypnosis and Imagery

No. 10 HELEN SINGER KAPLAN, M.D., PH.D., P.C.
Inhibited Sexual Desire, Sexual Phobias and Panic Disorders: Diagnosis and Treatment

No. 11 PAUL FLEMING, M.D., D.H.S.
SAR Workshop—Part 2

No. 12 JAMES MADDOCK, PH.D.—NOEL LARSON, PH.D.
On Supervision—Becoming Certified—Part 1

No. 13 MICHAEL CARRERA, ED.D.
Adolescent Pregnancy Prevention—The Children's Aid Society Model

No. 14 JOSEPH PURSCH, M.D.
Chemical Addictions

No. 15 KAY FRANCES SCHEPP, ED.D.
Assessment and Treatment Planning in Sex Counseling

No. 16 TO BE ANNOUNCED

Evening Workshops—7:00 to 10:00 pm

No. 17 ALBERT ELLIS, PH.D.
Combining Brief Therapy with Sex Therapy—The R.E.T.

No. 18 NANCY FRIDAY
Fantasy

No. 19 PAUL FLEMING, M.D., D.H.S.
SAR Workshop—Part 3

No. 20 JAMES MADDOCK, PH.D.—NOEL LARSON, PH.D.
On Supervision—Becoming Certified—Part 2

No. 21 ANN WELBOURNE-MOGLIA, PH.D.—RON MOGLIA, ED.D.
Sex Education Strategies—Outwitting and Outmaneuvering Your Opponent

No. 22 PATRICK CARNES, PH.D.
Sexual Addictions—The Nature of the Illness—Myths or Realities

No. 23 DAVID SCHNARCH, PH.D.
New Paradigms for the Treatment of Intimacy and Inhibited Sexual Desire Disorders

No. 24 TO BE ANNOUNCED
Gay Couples

THE SCOPE OF THIS CONFERENCE

Many of the distinguished workshop leaders will be participating in other portions of the conference program.

In addition, this conference will highlight many of the major issues of today: "AIDS: THE NATIONAL EMERGENCY"—"CONTROVERSIAL ETHICAL DILEMMAS"—"THE NPT CONTROVERSY"—"THE IMPAIRED THERAPIST"—"SEX IN SPACE"—"PRE-TEEN SEX"—"THE SEXUAL EXPLOITATION OF THE DISABLED"—"IMPOTENCE–THE NEWEST SOLUTIONS"—"SEXUAL ISSUES IN DIVORCE"—"SEXUALITY IN THE FETUS AND THE NEWBORN"—practical matters such as LIABILITY, BAD FAITH INSURANCE, MEDIA RELATIONS, even HOW TO GET PUBLISHED. And, "THE PSYCHOLOGY OF SERIAL RAPE MURDERERS" and other sexual crime victim and offender topics. And, special material for the military—such as "THE EFFECT ON RELATIONSHIPS OF EXTENDED SEPARATION," and "THE AFTERMATH OF THE MEESE COMMISSION."

There will be even MORE:

Many of the Living Legends in Sex Therapy, and Sex Education will be on the program.

AND we'll meet DR. RUTH WESTHEMIER (What Does the Public Want?)—SOL GORDON, Ph.D. (The Future of Sex)—DAVID SCHNARCH, Ph.D. (Intimacy)—PEGGY PAPP, MSW (Family Therapy)—JUNE REINISCH, Ph.D. (Kinsey Research)—ROBERT BUTLER and MYRNA LEWIS (Sex After 40)—MATHILDE KRIM and WILLIAM LEDGER, M.D. (AIDS)—SUE SPRECHER (Producer, The Donahue Show)—ALAN THICKE (Star GROWING PAINS) on Sex in the Media, as well as presentations by RAUL SCHIAVI, M.D., CLOE MADANES, MARK SCHWARTZ, Sc.D., LOUISE TYRER, M.D., RALPH EARLE, Ph.D.—THE MAYFLOWER Madam, Mary . . . MARY CALDERONE, M.D., RON HAZELWOOD (FBI) on Serial Rapists, PEGGY BRICK, M.A. and Many More!

The COMPLETE program will reach you in January!

SPECIAL HOTEL RATES

The breathtaking new MARRIOTT MARQUIS HOTEL is the venue for the Annual Meeting. SPECIAL AASECT conference rates—single or double—will be $120 plus tax. You can arrange to share a room thru the AASECT National Office—and cut the rate in half. Rooms customarily run from $175 to $250. A reservation card will be sent with your registration confirmation.

TAX DEDUCTION FOR EDUCATION

Treasury regulation 1.162-5 permits income tax deduction for educational expenses. These tax advantages may not be available under 1987 tax reform. If tax advantage is important to you, expenses PAID during the 1986 calendar year WILL be deductible from 1986 tax returns.

SPECIAL ACTIVITIES

New York! The Big Apple! Theatre—museums—fine food—shopping—concerts—galleries. AND the Annual Meeting will offer such exciting events as the AUTHORFEST reception highlighting authors and new books: The AASECT Awards Luncheon; Poster sessions; Roundtables; the invitational Film and Video Previews; special displays and exhibits; PLUS off-site activities such as Broadway shows, Scenic Boat tours of Manhattan Island, and the Statue of Liberty. (There are ELEVEN Broadway theatres adjacent to the conference hotel.)

AUDIO AND VIDEO TAPES

Individual audio or video taping of workshops or conference presentations will not be permitted. Audio tapes will be made available in the exhibit area.

AUTHORFEST, FILM FESTIVAL, EXHIBITS

AASECT members wishing to present their book(s) in the popular AUTHORFEST reception, producers wishing to submit films and video material for consideration for inclusion in the INVITATIONAL FILM and VIDEO PREVIEW scheduled screenings, and companies, institutions, publishers, agencies, and individuals interested in purchasing ad space in the conference program or in exhibiting at the Annual Meeting are invited to contact SANDRA COLE, EXHIBITS CHAIR, at **University Hospital, 1H221/0050, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0050.**

AASECT MEMBERSHIP

The AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS and THERAPISTS, is a national, multidisciplinary organization of professionals in the field of human sexuality. The Association offers certification in Supervision, Therapy, Counseling, and Education. The National Office is located at Eleven Dupont Circle N.W., Suite 220, Washington, D.C. 20036-1207. Phone (202) 462-1171. A membership application is included in this brochure.

PRESS CREDENTIALS

As in previous years, when the Annual Meeting has been held in New York, there is extensive press interest in the presentations, the speakers, and the issues. Press credentials will be required for all media covering the meeting. Contact Bill Stull, 2333 N. 3rd Street, Phoenix AZ 85004.

STUDENT MEMBER VOLUNTEERS

Student members are needed to assist at the Annual Meeting. Volunteers will be reimbursed full registration for one day of work (approximately 8 hours). Interested student members should contact Dr. Sandra Caron, Peer Sexuality Program, 202 Steele Hall, Syracuse University, Syracuse, New York, 13244-1120.

The spectacular new 1,877-room New York Marriott Marquis, located on Broadway in the heart of the theater and entertainment district, reflects the excitement and vibrance of New York City.

Dear Colleague:

As you can see in this preliminary program brochure, the XXth Annual Meeting of AASECT is going to be truly memorable!

Our twentieth year of service is a milestone. A celebration of our formative years—an acknowledgement of the evolution and maturity of sex education and sex therapy—and a commitment to the future.

When you review the course content of the *24* Pre-Conference Workshops—and when you note the stature of the distinguished faculty, you will get an idea of just how special this meeting is going to be.

The major issues outlined in THE SCOPE OF THIS CONFERENCE section and the highlighting of some of the featured speakers on the program should raise your enthusiasm—and pride, as it has ours.

Plans call for a repeat of the exciting AUTHORFEST reception. There'll be an invitational schedule of FILM AND VIDEO previews. New York members are working on arranging a Circle Line boat tour of Manhattan Island. Our hotel is adjacent to ELEVEN Broadway Theatres.

Special attention has been paid to the needs of EDUCATORS. Please note—just as an example—Pre-Conference Workshops 5, 13, and 21 . . . . with TATUM, CARERRA, and the MOGLIAS. CALDERONE—REINISCH—GORDON and others will offer related material during the program. And, there is a special focus on SEX COUNSELORS—including the KAY FRANCES SCHEPP workshops.

A $120 hotel rate (usually $175–$250) which you can CUT IN HALF by sharing a room—provides access to on-site accommodations for everyone! AND Meeting and Workshop fees are being offered to members now at special EARLY BIRD rates—that are BELOW last year!! (And, of course, early registration and payment assures tax advantages for the 1986 fiscal year.)

Innovative topics, critical issues, the participation of the living legends of our field . . . countless USEFUL learning opportunities. There will even be business matters—such as How To Get Published—Liability, Bad Faith Insurance—Preparing Yourself for Media—and more.

The complete program will reach you in January. But we sincerely hope that you will make sure your space and your workshop choices are secured by registering now—especially at those EARLY BIRD special rates.

See you in New York April 29th!

The Program Committee

"EARLY BIRD" REGISTRATION—AASECT XX ANNUAL MEETING
"THE POWER OF SEX"—APRIL 29–MAY 3, 1987
Marriott Marquis Hotel—NEW YORK CITY

Early bird advance registration rates are offered for a limited time only so that AASECT members might have first opportunity to select workshops, reserve a place at the meeting, and to realize 1986 tax advantages.

Name: _____ Degree: _____ Phone: (___) _____

Address: _____ City: _____ State: ____ Zip _____

Meeting registration fee enrolls the individual in all sessions and activities April 30 thru May 3, including Authorfest Reception, Poster Sessions, Roundtables, Break-Out and Plenary Sessions, Awards Luncheon, and Invitational Film and Video Preview. A separate registration fee for pre-conference workshops is required.

CATEGORY	QUANTITY	EARLY BIRD thru Dec 31	REGULAR thru April 15	AT DOOR	TOTAL
AASECT Member	_____	$165	$185	$195	_____
Non-Member	_____	$265	$285	$295	_____
Student–full time	_____	$ 85	$ 95	$105	_____
Daily (Single Day) **Does not include luncheon**	_____	$ 75	$ 95	$110	_____
Pre-conference workshops (members)	_____	$ 35 each	$ 45 each	$ 55 each	_____
Pre-conference workshops (non-members)	_____	$ 45	$ 55	$ 65	_____

Select workshops by number: **Morning Workshop No.___ Afternoon Workshop No.___ Evening Workshop No.___**

IF you become a member of AASECT at the same time you register for this conference, $50 of the registration fee will be applied to the MEMBERSHIP fee.

Refunds will be issued provided that written notice of cancellation is received no later than March 16, 1987. Telephone cancellations will not be accepted. An administrative fee of $50 will be charged for refund of member registration—$75 for non-member registration.

Payment enclosed
Check _____ **Purchase Order** _____ **Credit Card M/C** _____ **Visa** _____

Acct No. _____ **Exp. Date** _____

_____
Signature

Check here if you are interested in the room-sharing plan _____

Mail to: AASECT XX Annual Meeting
Suite 220
Eleven Dupont Circle NW
Washington DC 20036-1207

AASECT

American Association of Sex Educators, Counselors and Therapists

Eleven Dupont Circle, N.W. • Suite 220 • Washington, D.C. 20036 • (202) 462-1171

MEMBERSHIP APPLICATION

Name _____ Phone ( ) _____
(last) (first) (mi) (degree)

Address _____

City _____ State _____ Zip _____ Country _____

If institutional membership, names and degrees of two additional staff members.

_____
(last) (first) (mi) (degree)

_____
(last) (first) (mi) (degree)

Sponsor: _____

Membership Category:	January–December	July–December
☐ Full Professional	$ 100	$ 65
☐ Student *(proof of fulltime status is required)*	$ 35	$ 20
☐ Institutional *(three members may join as an institution)*	$ 250	$160
☐ Life *(one-time fee)*	$1000	

Following my acceptance as an AASECT member, I would like to receive information regarding AASECT certification in the category marked below:

☐ AASECT Certified Sex Educator

☐ AASECT Certified Sex Counselor

☐ AASECT Certified Sex Therapist

☐ AASECT Certified Supervisor

Enclosed is my check made payable to AASECT for $_____ (U.S. funds) for my AASECT membership dues in the category marked above.

I hereby certify that if my application for membership in AASECT is accepted, I will abide by its Bylaws and Code of Ethics.

_____
Signature

_____
Date

AASECT
Suite 220
Eleven Dupont Circle N.W.
Washington DC 20036-1207

PLEASE POST OR SHARE THIS BROCHURE

The world-famous Statue of Liberty, by sculptor Frederic Auguste Bartholdi, stands in towering majesty at the entrance to New York harbor. Her head is surrounded by a radiant crown while her feet step forth from broken shackles. Lady Liberty with upraised torch has welcomed visitors to The Big Apple for 100 years. (Photo courtesy of the N.Y. Convention and Visitors Bureau.)

NEW YORK CITY

"The showplace of the nation," Radio City Music Hall Entertainment Center is a must-see for every visitor to The Big Apple. Located in the Rockefeller Center complex, on the Avenue of the Americas at 50th Street, the Music Hall has a seating capacity of 6,000. (Photo courtesy of the N.Y. Convention and Visitors Bureau.)

Legal Issues

AASECT's legal counsel, Steven L. Engelberg, in a response to a query from the Executive Director, has addressed the impact of the recent Supreme Court decision on the Georgia sodomy law.

The case, *Bowers v. Hardwick,* brought out some questions on the effect on educators who teach about homosexual issues, including sodomy. In his reply to Dr. Hunt, Mr. Engelberg writes

"The *Bowers* case itself involved the challenge of Michael Hardwick, a practicing homosexual, to a Georgia statute which criminalized consensual sodomy. The Court went to great lengths to emphasize that this opinion deals *only* with the validity of the Georgia statute as applied to consensual homosexual sodomy and does not address the constitutionality of the statute as applied to other acts of sodomy. The Court addressed the limited issue of whether the U.S. Constitution confers a fundamental right upon homosexuals to engage in sodomy, thereby invalidating a state statute criminalizing such activity.

"In rejecting Mr. Hardwick's challenge of the Georgia statute, the Supreme Court was unpersuaded by the argument that consensual homosexual sodomy within the privacy of one's home is constitutionally insulated from state proscription. The Court refused to extend a constitutional right to privacy to such activity, making clear that cases such as *Roe v. Wade* (holding that a woman's decision to have an abortion, at least within the first trimester, is absolutely protected by a right to privacy derived from constitutional concepts of liberty) do not stand for the principle that all activities conducted within the privacy of one's home are protected. Accordingly, the Supreme Court upheld the Georgia statute, as applied to consensual homosexual sodomy.

"The scope of the *Bowers* decision, therefore, is very limited. The Court addressed only the validity of statutes which criminalize consensual homosexual sodomy.

"To the extent sex educators merely teach others about such issues as sodomy, and do not foster or condone the conduct itself, there would seem to be no violation of laws regulating the act of sodomy. Therefore, the *Bowers* decision itself has no apparent application to sex education.

"However, as you know, we have not at this time conducted any examination of state laws regulating sodomy. My guess is that few (if any) of these laws attempt to outlaw the teaching about sodomy by educators or others. Furthermore, I believe that any attempt to regulate the mere teaching about sodomy by sex educators would pose serious questions, and raise significant First Amendment and other constitutional issues."

Goals

(Continued from page 4)

and the serious medical threat of AIDS epidemic, there is a tremendous, necessary reinvestment in relationships. Casual sex is over, although many people do not know it yet. The sexual revolution has spoiled a generation of our society in a nice way. Many expect to find sexual and emotional satisfaction in variety and now need to learn how to create the condition within monogamous relationships until the threat of disease and the threat of politics passes, enabling us again to explore unusual possibilities. Let's be the best and settle for nothing less.

Next I would like to itemize more concrete goals, and I hope that when my year is over you will refer back to these ambitious plans and rate us by these standards. It will become immediately clear to everyone who reads these pages that these goals cannot be achieved by one person alone. If we are successful I could not possibly take the credit. If we are not successful the failure will not be mine alone. I intend to complete as many of the following objectives as possible, not necessarily in the order in which they are listed.

(1) A combined membership and certification roster which includes membership demographics to be circulated to the membership prior to next April's Annual Meeting.

(2) The development of a meaningful, quality lecture and media bureau that provides a reference list of our members capable of reflecting well on the organization through their media presentations and interviews. This lecture and media bureau and the individuals participating therein will not speak for AASECT in the words they use or in the interviews they give—they will speak for AASECT only in the manner in which they present themselves and the intelligence of their thoughts, because, as AASECT members, it will reflect on us all.

(3) Drug registry: AASECT can offer a unique service to AASECT, medicine, and other organizations by recording and identifying medications through a central clearing house that affect sexual function in a positive or a negative way and collating anecdotal information ultimately resulting in meaningful, statistically valuable data to be shared with the membership, the FDA and pharmaceutical companies. (This objective is contigent upon funding.)

(4) The development of an AASECT hot line with a series of 3-minute tapes on a broad variety of subjects most relevant to commonly asked questions. (This objective is also contingent on funding.)

(See *Goals* page 12)

Supervisors

(Continued from page 1)

Applicants must then submit a summary of their work with one sex therapy supervisee during the past year. The summary must describe the number and nature of the sessions and the learning process and outcomes. There should be an emphasis on process issues, and the summary must include an evaluation of the supervisee.

In addition, the applicant must choose one of three options. An applicant can submit the names and addresses of three current AASECT Certified Sex Therapists who will attest to the supervisory qualifications of the applicant. If this option is selected, the applicant must request that the three therapists send a letter of reference regarding the candidate to the Supervisior Certification Committee. The applicant can choose to demonstrate a minimum of five years of experience as a provider of clinical supervision. If an applicant chooses this option, the director or administrator of the clinical service must supply a letter of reference for the applicant. The applicant can also fill this requirement by documenting designation as an approved supervisor in an allied professional field.

The applicant must also submit a non-refundable processing fee with the application.

Certified Supervisor status will be granted for a period of five years at which time Certified Supervisor may apply for renewal. At the time of renewal, applicants must submit the appropriate fee and show evidence of active work in a supervisory capacity. In addition, they must also be in compliance with supervisory requirements in effect at the time of renewal.

After August 31, 1987, new requirements will be in place for those Certified Sex Therapists wishing to apply for Certified Supervisor status. First, the applicant must hold a regulatory license and/or certificate in the state in which he or she practices in the area of psychology, medicine, psychiatric nursing, social work, or marriage and family therapy. In states where no regulatory system is in effect, the applicant must meet one of the following criteria:

Listing in the *National Register of Health Science Providers in Psychology*

Certification by the American Board of Psychiatry and Neurology

Certification by the Academy of Certified Social Workers

Clinical Membership in the American Association for Marriage and Family Therapy

Certification by the American Nursing Association as a Clinical Specialist in Adult Psychiatric and Mental Health Nursing or Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing

Applicants from outside the United States must document equivalent certification.

Applicants must also document on-going clinical practice of sex therapy for a minimum of five years with at least three of those years as an AASECT Certified Sex Therapist. In addition, applicants must document a minimum of two years in a clinical supervisory capacity.

Applicants must also be able to show a minimum of thirty hours of individual supervision of the applicant's supervision of sex therapy from an AASECT Certified Supervisor. This supervision is expected to include material from two supervisees. They must also document attendence at an AASECT workshop focusing on the skills essential for the supervisory process.

The candidate must also have letters of reference from two professional colleagues other than his or her supervisor that evaluate the candidate's supervisory ability. As in the grandparent year, candidates are also requested to submit a written summary of at least one sex therapy supervisee. The application must also be submitted with the appropriate fee. Application forms and forms requesting letters of reference are available from the National Office. Questions about the new certification should be sent to the National Office to be forwarded to the Chair of the Certified Supervisor Committee.

Workshops

(Continued from page 3)

"Second National Nursing Conference on Violence Against Women" is the title of the conference sponsored being sponsored by the Division of Nursing and the Division of Continuing Education at the University of Massachusetts at Amherst. The conference is being held to foster the dissemination of ideas, knowledge, research and clinical and educational strategies in the area of violence against women. It will provide a forum for nurses and other health care professionals to meet and share knowledge and ideas. Keynote speaker is Jacqueline Campbell. The conference will be held March 13–15, 1987 on the campus of the University of Massachusetts in Amherst. For more information, contact Judy Wardlaw, Division of Continuing Education, Health Sciences Program, Goodell Building, University of Massachusetts, Amherst, MA, 01002 (413) 545-0312.

Goals

(Continued from page 10)

(5) Membership drive: The membership drive begins with a quality organization of such excellence that it is irresistible to our present members and attracts new members, while recapturing old, disillusioned members.

(6) A superlative Annual Meeting that draws from beyond our field and establishes AASECT as a relevant, meaningful, and essential discipline within all disciplines.

(7) The revitalization of our regions and the perpetuation of our grass roots philosophy.

(8) A brief written history of AASECT by Shirley Zussman, Ed.D. to be included in an AASECT brochure made available to any members or outside inquiries curious about our organization.

(9) Increasing and improving membership services, including but not limited to increased networking opportunities, legal updates, AIDS guidelines, improved newsletter, etc.

(10) Conference guidelines that can be used in planning future conferences will be updated which will include standard workshops and presentations that warrant repetition and updating at each Annual Meeting, in addition to our varied, new and individual presentations.

(11) Long-term conference planning to ensure continuity which includes but is not limited to establishing sites and hotel negotiations for the next four or five years.

(12) Beginning work on guidelines for certification by AASECT of continuing education programs of other organizations.

(13) The development of meaningful recertification guidelines.

(14) The completion of our bylaws for Board review and acceptance at our January meeting and for acceptance by our general membership by our April Meeting, unless our legal counsel determines that membership voting can be done by mail, in which case acceptance of the bylaws by the membership will be accomplished at a significantly earlier date.

(15) Development of the continuing education program.

(16) Excellence in courtesies to our membership, our staff, and our board members, as well as sister organizations and affiliate organizations. A Board member has been appointed to give personal attention to this etiquette.

(17) Upgrading the professional quality of our journal and our newsletter.

(18) Mending, integration and reconciliation inside and outside our membership.

(19) To begin integration and liaison with other different but related organizations.

(20) To pursue closer working relationships with SSSS, SIECUS, SSTAR, and EST with closer cooperation of our organizations.

(21) For our Board to be an aggressive working board with committee function during our first and second board meetings. By our April Board Meeting I look forward to the evolution of the Board from committee work to the effective directorship it has the potential to be.

(22) The development of AIDS guidelines for our educators, counselors, and therapists.

Obviously, this is an ambitious series of projects. We can make our destiny happen instead of waiting for destiny to happen to us. Freight trains usually get where they're going, especially if all of the cars are heading in the same direction. We can do that. I welcome all the help I can get. I need it, because without you, none of this can be accomplished. This is an open invitation to help me now and to use this letter as a frame of reference to judge us later.

AIDS

(Continued from page 7)

will you advise a married patient who is having an affair? What will you recommend to a patient who is frequenting prostitutes? Are you going to continue recommending surrogates? If so, what precautions should be taken? What is the therapist's liability if a patient contracts AIDS through surrogate sex therapy? Should you modify your advice relating to dating skills? How will you teach your patients to confront the sexual health issue in the course of developing relationships with others? What will your position be on casual sex and one-night stands? What will you tell your own children about AIDS if they are teenagers emerging into the world of sexual maturity, or if they are single adults? Let your thoughts about the advice you would give your children guide you in the development of recommendations you would suggest to your students, clients and patients.

Have the courage to search your soul and speak out regarding your opinions about responsible actions concerning the AIDS epidemic. AIDS is everyone's concern. Yours especially because you reach students, clients and patients who are concerned about their sexual lives. If you act responsibly as AASECT members, you can be the most powerful force against the spread of this epidemic that exists as a resource in society today. Take the responsibility to become informed and follow through by informing all of those that you can reach. You have the power to save lives, if you exercise it.

Annual Meeting

(Continued from page 1)

Registration fees vary according to membership status. Moreover, early registration is a bargain at $165 for AASECT members.

Preconference workshops are planned for the Annual Meeting, with morning, afternoon, and evening sessions. Therefore, it would be possible to take three of them, except in the case of the SAR which in and for itself runs for all three sessions or a full day and evening.

Preconference workshops are $35.00 each for members with the "early bird" registration. If non-members join AASECT at the time of their registration, $50.00 of their registration fee will be applied to the membership fee of $100.00.

The subjects of workshops were determined on the basis of the market survey sent out with the call for papers. Although there will be no cancellations of preconference workshops because of low registration, there are not an unlimited number of places in any of them. Therefore early registration is recommended in order to be sure of obtaining a place in the one or ones wanted.

A wide variety of speakers and presentations have also been planned for the Annual Meeting, including Sol Gordon, Ph.D., on "The Future of Sex," Robert Butler and Myrna Lewis on "Sex After 40," Alan Thicke, star of "Growing Pains," on "Sex in the Media," June Reinisch, Ph.D., on Kinsey research, and Ruth Westheimer, Ed.D., on "What Does the Public Want?"

The Annual Meeting will provide excellent opportunities for networking. There will be an opportunity to post job announcements and other items of interest.

Member News

(Continued from page 5)

The Spring/Summer issue of *Sexuality and Disability*, a journal devoted to the study of sex in physical and mental illness features 3 articles by AASECT members. The journal which consists of original papers concerning normal and abnormal sexual functions includes the papers of **John Money, Ph.D., Mary Valentich, Ph.D., James Gripton, D.S.W., Timothy O'Ferrell, Ph.D. and Diane Logan Thompson, Ph.D.**

Mark Schoen Ph.D., has reactivated Focus International, Inc. As a producer and distributor of films, video, and other media for the human sexuality community Focus International will act as the exclusive distributor for the sex education films of Dr. deryck calderwood, the sex therapy films of Dr. Joseph LoPiccolo, the award winning, "Bellybuttons Are Navels" and "Sexual Anatomy and Physiology" by Drs. Leon and Shirley Zussman.

Cheryl Gillespie, R.N., Ph.D., AASECT's Treasurer recently completed her doctoral studies at Virginia Tech in marriage and family therapy. The title of her dissertation was "Marital Therapists' Own Marital Distress and Its Perceived Impact on Their Clinical Work." An abstract of her research has been submitted to AASECT's program committee for the annual meeting in New York in 1987. Dr. Gillespie plans to continue in private practice with her husband, Hal, a psychiatrist, in Radford, Virginia.

OBITUARY

At its meeting on September 21, 1986, the Board of Directors of AASECT took note of the death on August 7 of **deryck calderwood,** one of the outstanding sex educators of our time. He was unconventional not only in his carefully bleached hair and in his insistence that his name be spelled without capitals, but also in the remarkable contributions he made as Director of the Sexuality Program in the Department of Health Education at New York University and in the imaginative teaching aids he developed for sex educators, particularly those in the Unitarian Church.

For many years deryck was a key Board Member for our sister organization, the Sex Information and Education Council of the U.S. (SIECUS). Beneath a rather shy and quiet exterior was a learned professor, a profound philosopher, an erudite bibliophile, a talented filmmaker of explicit visuals and a warm and passionate individual. Thousands of students, colleagues, friends and others are grateful for the privilege of having known him, a privilege that, unfortunately, future generations cannot directly share. The Board extends its sympathy to his widow and children.

RICHARD CROSS, M.D.
DISTRICT VI CHAIR

Member Interest Low in Legal Services and World Congress

Response was low to surveys published in the most recent *AASECT Newsletter.*

Members were asked to indicate an interest in using legal services provided through AASECT, as well as their interest in attending the 8th World Congress for Sexology in Heidelberg, Germany in 1987.

Ten members indicated some interest in a group legal services plan. Three members indicated they would not be interested in such a plan. One member explained that he has a similar plan offered through the APA.

The plan, proposed to the Board of Directors, would offer licensed attorneys to answer telephone inquiries and follow up with written documentation, as well as local counsel referrals and a quarterly newsletter.

Fifteen members indicated varying degrees of interest in the World Congress for Sexology. Gabriel V. Laury, a member from New York, may present a paper at the World Congress.

If you would like additional information on the World Congress, please write to them directly at the following address: Organizing Secretariat, 8th World Congress for Sexology, P.O. Box 106020, D-6900, Heidelberg, Germany.

Healthy Living is Theme of World Health Day

World Health Day (WHD) is observed April 7 each year in 166 countries and the United States. In the United States, the American Association for World Health sponsors the event together with the Pan American Health Organization and the U.S. Department of Health and Human Services.

World Health Day 1987 will be an action-oriented celebration co-sponsored by more than 200 non-profit organizations and carried out by thousands of health departments, schools, universities, hospitals and other community service groups. The theme, "Health Living: Everyone A Winner," links healthy lifestyles to the well-being of the family, the community, the nation and the world. "Health Living" also promotes good health as an individual responsibility.

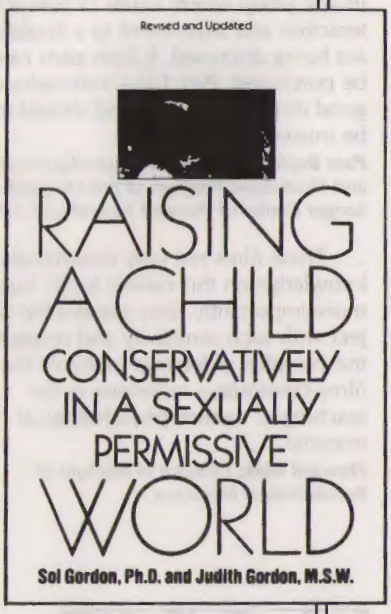
This year, special emphasis will be placed on immunization, a pertinent global issue for persons of all ages.

- Under-utilization of immunization costs the lives of 3.5 million children each year.
- Senior citizens are at special risk to diseases in which immunization can provide protection.
- College students are at risk, with major outbreaks of measles and influenza on the increase at colleges and universities across the country.
- Preschoolers in many day-care centers and nursery schools are not required to be immunized.
- Inaccurate reporting of immunization statistics and the concept of "herd immunity" has created a false sense of security among Americans.

For free information on WHD, please write the American Association for World Health; 2001 "S" St., N.W. Suite 530; Washington, D.C. 20009, or call (202) 265-0286.

National Office Needs Archive Materials

Because of various moves and changes in personnel, the National Office has little in the way of archives. Particularly needed are past issues of both the *Journal of Sex Education and Therapy* and the *AASECT Newsletter.* Members who have past issues of either or both are urged to send them to the National Office for permanent filing. Should duplicate issues be received, they will be placed in another file for distribution to libraries that request them. None of these issues will be destroyed.



Now available in paperback!

Fireside Books is pleased to present the first paperback edition of this acclaimed guide for parents bringing up their children in today's "post-sexual revolution" era. Written with sensitivity and insight, *Raising a Child Conservatively in a Sexually Permissive World* helps parents and children find a middle ground between the confusion of "anything goes" and equally damaging sexual censorship. Addressing sex education issues, as well as related subjects such as homosexuality, sexually transmitted diseases, pornography, and cohabitation, the authors stress open communication—how to be an "askable parent"—in a reassuring work that seeks to foster maturity and responsibility through honesty and informed choice.

Take advantage of our Special Discount Offer!

Raising a Child Conservatively in a Sexually Permissive World is available at special discounted prices on orders of 10 or more copies (orders of fewer than 10 copies may be obtained through local booksellers). Discount rates are as follows:

Number of Copies	Price per Copy*
10–49	$6.74
50–99	$5.65
100+	$4.21

Suggested retail: $7.95
*Shipping and handling included

To take advantage of this special offer, simply fill out the accompanying order form and mail to:

Simon & Schuster, Inc.
1230 Avenue of the Americas
New York, NY 10020
ATT: Martha Reddington
Special Sales Dept.

F

Please send ____copies (minimum of 10) of the trade paperback edition of *Raising a Child Conservatively in a Sexually Permissive World* @ $ ____each. Enclosed is a check payable to Simon & Schuster, Inc. in the amount of $ ____.

PLEASE ALLOW 3–4 WEEKS FOR DELIVERY. BOOKS ARE SOLD ON A NON-RETURNABLE BASIS.

Ship to:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Choices: In Sexuality with Physical Disability

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

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

Choices examines the day-to-day practical considerations confronting disabled men and women seeking sexual identity and fulfillment. This is a two-part film with a problem/ solution approach to various disabilities including paraplegia, quadriplegia, ileostomy, and cerebral palsy. Overcoming fear, meeting partners, incontinence, discovering sensation and communication are some of the issues discussed by each person in the film.

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International Rehabilitation Film Festival

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. . . Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed . . .
Pam Boyle, Coordinator: Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood. NYC.

. . . These films not only disseminate knowledge on this central topic, but, more importantly, they present the subject with such sensitivity and respect for the complex of feelings invloved that the films constitute a milestone in the teaching of medico-physchological material . . .
Howard Rusk: Director of Institute of Rehabilitation Medicine.

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Surgeon General Everett Koop

Recent remarks encouraging sex education in schools could be the first major step in arresting the progression of AIDS. Prevention through education is the key. It requires no miracles, no research. The massive public education campaign he now suggests is now overdue.

However, if the wrong information is given, the effort will fail. It will cause death rather than prevent it. The responsibility is a grave one.

Surgeon General Koop has recomended teaching "Safe Sex" practices centering around the use of condoms for protection. But condoms are not as safe as the public has been led to believe. While in most laboratory experiments, they do not pass sperm, herpes or the AIDS virus, in practice, they have a 10% failure rate for pregnancy. A woman is able to get pregnant only three to five days a month. She is susceptible to AIDS 365 days a year. Fact: Sperms are 500 times larger than a virus. Often overlooked is the fact that sexual arousal is much like alcohol intoxication. The first thing to go is your judgement. Good intentions to use condoms may disappear in the heat of passion. Teenagers are notorious for carrying condoms in their wallets and leaving them there. Condoms are no protection in your pockets. Taking these factors into consideration, common sense suggests that the failure rate for the AIDS virus will be much higher than 10%.

When you have sex with someone, you are having sex with everyone that they have had sex with during the past five to seven years. AIDS, like taxes, is retroactive. You may be able to judge an individuals character, but you cannot evaluate all the others. It is impossible to be selective. The only safe sex is celibacy, or masturbation. Next best, is monogomy with a trustworthy partner who is not already infected. Unless these recommendations are the ones taught in school and to society at large, the education campaign will simply perpetuate myth and misinformation - postponing but not preventing.

Saying that use of condoms is "safe sex" is in fact playing Russian Roulette. A lot of people will die in this dangerous game. Cases have already been reported of women who developed AIDS while depending on condoms for protection. Two women out of 12 who continued to have sex with their partners who had AIDS, while depending on condoms for protection, have become infected with the AIDS virus . Given the presumed safety of condoms, this is a "very disturbing finding" according to Dr. Margaret Fischl, the study director.

A 10% or greater risk of being exposed to a deadly incurable disease is not safe in my opinion. I don't like the odds.

The spread of the AIDS virus within our population demonstrates that our efforts to date are not sufficient. AIDS is not killing us, behavior is. Survival or extinction is our choice. The AIDS virus will win the game of Russian Roulette if we don't act more responsibly now. Do we have the discipline and courage to make the right choices or will we continue to mislead ourselves and others until it is too late?

This epidemic can be beaten, but only by eliminating the risk. Reducing the risk is important but not enough. Gambling with our lives, hiding from the truth, is not the solution. The AIDS virus will not get you without your cooperation.

There is a solution, but it can no longer be half measures. For the sake of health, casual sex and so called "safe sex" practices must be abandoned. Celibacy, masturbation or monogamy in a trustworthy relationship will stop the spread of this disease. If today, everyone were magically frozen with their present sexual partner, we would not have very many cases of AIDS tomorrow. This is not realistic, but we can aim for quality relationships instead of quantity. Most people erroneously believe that you can't significantly change someones sexual behavior. These opinions come from individuals not expert in the field of human sexuality. Sexual behavior can change, but not unless we expect it and recommend it.

The AIDS epidemic is forcing us to develop qualities that are not undesirable: trustworthiness, intimacy, commitment, compassion. The quality of monogamy will improve. Patients are already coming to my clinic for marriage and sexual counseling who would have simply gotten a divorce a few years ago. They say "It's a terrible time to be single. I don't like him/her much either. Please help us improve our relationship so that we will want to stay together." Married men and women who used to supplement their relationships sexually on the outside are coming to therapy in an effort to improve their relationship enough so that they won't want to stray. Singles are coming to me because

they are afraid of getting AIDS and too embarrassed to bring the subject up on a date. They need to learn an entirely new set of social skills which can be accomplished relatively easily with the right guidance.

Within a committed relationship, the quality and quantity of sex can be unrestricted. Sex need not be limited, dull, boring or handicapped in any respect whatsoever. Life can still be fun and full of romance. However, outside that relationship, sex of any kind can be fatal. The choice is ours, will it be Russian Roulette or survival. Condom sense is not a substitute for common sense.

January, 1987

AASECT AIDS GUIDELINES

I. RATIONALE

Sex educators, counselors and therapists have a responsibility to know and understand the impact of AIDS on sexuality and the impact of sexuality on AIDS. The counseling, therapy and education provided by AASECT members will have a major impact on the behavior of clients, patients and students. If Acquired Immune Deficiency Syndrome (AIDS) is to be controlled, it must be through PREVENTION: informing individuals how to keep themselves safe. Counselors, educators and therapists must stay current on research and issues concerning AIDS and other sexually transmitted diseases to ensure that their clientele receive accurate and timely information.

Until research can provide effective solutions, our only weapon against AIDS is education. There is no other antidote at this time. Members of The American Association of Sex Educators, Counselors and Therapists (A.A.S.E.C.T.) must mobilize all possible resources to meet this challenge.

A.A.S.E.C.T. members can also benefit society by using their skills to improve the quality of intimacy, commitment and trustworthiness within relationships. Couples fearful of being single in today's world of STD's (sexually transmitted diseases) are working harder to stay married when divorce threatens, and will turn to therapists more and more often for help. Couples who are not infected can be taught how to

thrive and grow emotionally during these difficult times, making their relationships stronger, while developing the ability to meet their responsibilities toward those who are already infected and in need of help and support.

II. CONSIDERATIONS

A. Definitions of AIDS Virus Infections: Counselors, educators and therapists should be familiar with the various manifestations of the HIV (Human Immune Deficiency Virus) also known as the "AIDS Virus", Human T-lymphotropic virus type III (HTLV-III), and lymphadenopathy-associated virus (LAV), and to counsel their clients on the following:

1. Positive HIV test:

A positive HIV antibody test (see "AIDS Testing" below) indicates that a person has been exposed to the virus, has developed antibodies to the virus, and is presumed to be infected with the AIDS virus. There may be no symptoms. It is unknown exactly what percentage of antibody positive people will develop AIDS or AIDS Related Complex (ARC). Estimates vary: The most recent demonstrate that 60% (Lancet, May 24, 1986) of those infected will go on to manifest symptoms within three years. There are 10,000,000 persons estimated to be HTLV-III positive worldwide, according to Dr. Hafdan Mahler, leader of the World Health Organization. He predicts 100,000,000 in five years. HIV virus has

been cultured from the majority of asymptomatic HIV positive individuals. Because of this, someone who is a confirmed antibody positive is considered infectious for an indefinite period of time, presumably for life, and should be counseled about their behavior so they do not spread the disease to others.

2. AIDS-Related Complex:

AIDS-Related Complex (ARC) is characterized by chronic swollen lymph nodes, fever, fatigue, and general flu-like symptoms which persist more than a few weeks. ARC patients are sick, and the disease is in some cases fatal. ARC is not reportable, and so it is not known how many people have ARC, or what percent progress to develop AIDS. It is estimated that there are 1,000,000 cases of ARC worldwide. Many experts now believe that ARC is an earlier stage of AIDS and that there is essentially no other distinction between them. ARC patients are infectious and should be counseled about their behavior to prevent spreading the disease to others.

3. AIDS - Acquired Immune Deficiency Syndrome:

AIDS is the result of an infectious viral disease which attacks and destroys the body's immune system. In this weakened state, the body cannot protect itself from other infections. For AIDS to be diagnosed, a patient must have (an) associated

opportunistic condition(s) such as; Kaposi's sarcoma, pneumocystis carinii, hepatitis B, candida or cytomegalovirus, to name a few of the principal infections listed by the Centers for Disease Control (CDC) as a criteria for the diagnosis of AIDS. AIDS patients frequently have other diseases such as tuberculosis, herpes or other types of viral hepatitis. AIDS has an extremely high mortality rate and is apparently fatal in all cases. No one has been cured of AIDS. AIDS patients are infectious for multiple pathogenic agents and should be counseled about their behavior to prevent spreading the disease.

B. Modes of transmission:

Sex educators, counselors, and therapists must keep current on established modes of transmission to be able to counsel and instruct clients and students who are infectious on how to avoid spreading AIDS to others, and to counsel those who are not infected on how to avoid contracting the disease. Areas on which to concentrate are:

1. Homosexual and Heterosexual transmission

Infection with the AIDS virus is not exclusively a homosexual problem. Heterosexual transmission of the HIV virus through vaginal intercourse (from male to female and female to male) is documented and recognized by the Centers for Disease Control. Multiple exposures are not

necessary for disease transmission.

2. Contaminated needles

The HIV virus is readily transmitted via shared contaminated needles. I.V. drug abusers are at high risk due to their practice of sharing needles without adequate sterilization. This danger must be stressed to I.V. drug users.

3. Blood or blood products

Since the HIV virus is present in the blood of infected persons, it can be transmitted through transfusion or use of other contaminated blood products. Since 1984, blood banks have been screening for the antibody to the HIV virus. There have been very few cases of infection from contaminated blood or blood products since this screening began. There is a delay (approximately 2 weeks to 6 months or longer) for an antibody response to be developed by an infected person. Blood donated during this "window" of time will pass the screening tests but be unsafe, because the AIDS virus is present but no antibodies have yet developed. Caution: the newly discovered French and Swedish variations of the AIDS virus slip by the AIDS blood screening test in about 1/3 of cases. You cannot contract AIDS from donating blood.

4. "Casual" transmission and/or "environmental" transmission.

There has been much controversy over whether or not AIDS can be transmitted via casual contact. It is generally accepted that the HIV virus is not transmitted through casual contact, however, it may be another 5 to 10 years before all the facts are available. If casual transmission occurs, it would be a very inefficient means of transmission. The virus is not airborne. It is helpful to think of the risk of being infected as a continuum with direct blood contact with infected bodily fluid as the highest risk (as via shared needles or contaminated blood transfusions) moving down the scale to enclosing oneself in a plexiglass bubble posing the least risk. Patients with AIDS or ARC or who are HIV positive must be counseled to understand that their body fluids are infectious, and that they must learn to behave in ways that prevent others from coming into contact with their bodily fluids. Laws exist in many states that prevent anyone infected with AIDS from being ostracized or in anyway physically segregated from others. Infected persons must use good judgement and they must exercise meticulous personal hygiene and extreme self-responsibility to minimize the risk of spreading infection to others... and to insure their own safety and health as well.

5. AIDS "Dementia"

The HTLV III virus infects the central nervous

system - sometimes before any other symptoms of disease are present, but commonly after other manifestations of disease have occurred. Therefore, symptoms of brain involvement or "dementia" may appear. These patients may have impaired judgement as a result. Psychological manifestations in patients may, in some cases be due to infection of the central nervous system - a condition often difficult to diagnose. Those therapists dealing with depressed or mentally impaired patients must consider HIV infection as a part of the differential diagnosis when appropriate. Depression is usually associated with known HIV infection. There is some thought that in addition to the obvious and understandable psychological reasons, the depression may sometimes be associated with CNS involvement from AIDS. Therapists counseling AIDS patients should be aware of these issues.

C. Risk Groups.

It is essential that sex educators, counsellors and therapists understand the concept of risk groups and the limitation of the concept's usefulness. Risk groups are too often viewed as a means of denying one's own susceptibility to the disease. If a person has sex with someone who is infected, regardless of their label, he or she have been exposed to the virus and risk becoming infected. Once heterosexuals with multiple partners

became a high risk group, the concept became less relevant, because if you add all the various identified risk groups together, they comprise the majority of our society.

D. HIV testing.

1. Uses and limitations

The use and limitations of HIV testing is an extremely controversial, political issue. The counseling relationship is, by nature, confidential. Unless legislative changes are made, licensed psychologists, psychiatrists, physicians, marriage conselors, and social workers are prohibited from disclosing information revealed in consultation with a client. Confidentiality of test results are protected by law.

Before a counselor suggests HIV testing, he/she should have some familiarity with the tests and what they do and don't do. Knowledge of the laws affecting testing, confidentiality and reportability particular to that state is essential. The test for AIDS is a screening test for the AIDS antibody. The two most frequently used antibody tests are the ELISA and The Western Blot. The ELISA, used by most laboratories is extremely sensitive in detecting the presence of the antibody. If there is an error in the assay, it is most likely to be a false positive - indicating the presence of antibody when none is there. Because of this, one positive test should

not be taken to mean there is antibody present. The person with one positive test should be tested again. But one negative test by the ELISA method is very reliable. The Western Blot is often used to confirm a positive result on an ELISA assay. The Western Blot, by contrast to the ELISA, has very few false positives. A positive test by Western Blot test is considered reliable.

After being exposed to the AIDS virus, it can take from two weeks to six months or longer to develop antibodies, although the majority of people who become infected become antibody positive within six weeks of exposure. Some rare individuals who are infected never develop antibodies. Screening tests done before antibodies develop would show negative results, so performing the tests after a six week period of refraining from sexual activity would be the most accurate way to establish seronegativity for the HIV virus in the majority of individuals.

2. Clinical indications for testing

Clinical indications for HIV testing must be evaluated by the counselor on an individual basis. If a client is concerned that he/she may have been exposed to the virus and may be infectious, two questions should be considered:

a. Would knowing whether or not the individual is

positive for HIV be beneficial to the client?

b. Would knowing whether or not the individual is positive for HIV be beneficial to the loved ones and sexual partners of the client?

In both cases, the answer would be "yes". If the client is seronegative, the benefit is obvious: relief from undue worry and concern. Knowing one is seronegative allows for an opportunity to change the behavior that raised doubts in the first place. If the client is seropositive, there is still benefit. The client can change behavior to prevent spread of the disease to loved ones. The client can inform his/her sexual partners so they can establish their status, get tested and make behavioral changes as necessary to stop the spread of infection. The client can also take measures to improve al health and bolster the immune system which may prevent or postpone the progression of the disease. A confirmed seropositive person may live many years without manifesting any symptoms of AIDS, but because he/she probably carries live virus and is infectious, he/she has a moral responsibility to protect the health of those persons he/she contacts. Ignorance is no defense against AIDS.

The question of HIV testing on an individual and clinical basis should be answered through sensitive counseling, data-gathering, and self-responsible behavior. The counselor must be prepared

to assist the client in making a decision for or against testing, and to help them cope should the results indicate exposure and possible infection.

Some indicators for testing are:

a. Sexual contact with someone known to have AIDS, ARC, or HIV positive test.

b. Sexual contact with someone in a known risk group (homosexual or bisexual men, prostitutes, heterosexuals with multiple partners, I.V. drug users, hemophiliacs, or someone who received a blood transfusion prior to 1984).

c. Receiving blood products prior to 1984.

d. A history of multiple sexual partners over the past five years.

e. Someone who expresses concern - "the worried well" who needs reassurance.

E. Treatment techniques and vaccination.

Developments in vaccine research and medical management of the disease should be monitored by educators, counselors, and therapists. There is no current treatment which has been demonstrated to cure AIDS, nor is there a vaccination that is effective against the virus. Treatment currently focuses on slowing the progression of the virus and curing the opportunistic infections that accompany the disease. Azidothymide (AZT) is a treatment, not a cure. It is still under investigation but early results are

promising. It interrupts the progression of the disease but does not kill the virus. Side effects can be severe and it is in short supply.

III. SOCIAL CONCERNS AND ETHICAL ISSUES

AIDS is a disease with far reaching social, political, legal and ethical considerations. Each counselor, educator and therapist should take time to consider the various points of view on AIDS issues and develop a responsible position on these issues. Some areas to consider are:

A. Homophobic concerns and ethical issues: One of the most disturbing social consequences of AIDS is the damage done to the homosexual male community. As AIDS was initially labeled a male homosexual disease, most people felt the best way to avoid the disease was to avoid homosexuals. As the disease spread and gained notoriety, anti-gay sentiment has increased.

As sex educators, counselors, and therapists, we can advocate against the prejudicial treatment of male homosexuals by providing our communities with facts about AIDS contained in these guidelines.

B. Social Mores and Sexual Behavior: The advent of AIDS has necessitated rethinking and re-evaluating positions taken in social mores relating to sexual behavior such as adolescent sexual activity, sexual experimentaion, extramarital affairs, swinging, group sex, and casual dating sex. How does AIDS and other sexually transmitted diseases alter the advice therapists, counselors and

educators give to people, especially teenagers and singles, as well as married couples? Sexually transmitted diseases have been of concern to sexually active non-monogamous individuals, but STD's were, in the past, inconvenient and uncomfortable but not ordinarily life threatening. Will there someday be a law suit against a therapist who knew of high risk behavior but did not caution a patient about AIDS - i.e. one night stands, casual sex, multiple partners.

Sex educators, counselors, and therapists have a responsibility to inform their clients about sexually transmitted diseases in general, and AIDS in particular. Working with a client to develop a life style which permits both a healthy and satisfying sex life and a disease free body presents a tremendous challenge to the sex educator, counselor and therapist of today.

C. Transmission of AIDS through prostitution and IV drug use: With prostitutes and IV drug users being included in AIDS high risk groups and studies indicating that up to 70% of prostitutes in some areas are positive for HIV antibody, it is important for A.A.S.E.C.T. members to evaluate their position on prostitution and drug abuse from a public health viewpoint. What alternatives are available to prevent the spread of AIDS via prostitution? Some suggest a law enforcement crack-down on prostitution and drug abuse, while others support legalizing both as the only way to control the spread of disease by prostitutes through required health testing.

Should sterile syringes and needles be more readily available as suggested by some, or should efforts to prevent and/or prosecute these behaviors be escalated? As professionals in the field of sexology, it is our responsibility to assist in developing policies on this issue and generating the necessary data base to support the policies we develop.

D. Use of sexual surrogates in sex therapy: AIDS adds to the controversy surrounding the use of sexual surrogates in sex therapy. The sex counselor or therapist who uses surrogates in his or her practice must evaluate the potential for AIDS transmission via a surrogate, and should consider the following:

1. HIV testing for both client and surrogate (see IIC "HIV Testing" above).
2. Surrogates qualify as a high risk group - i.e. "heterosexuals or homosexuals with multiple partners".
3. What are the civil/criminal liabilities to the therapist should a client become infected with HIV from a surrogate the therapist prescribed?
4. What are the civil/criminal liabilities to the therapist should a surrogate become infected by a client the therapist referred?

E. AIDS legislation: Unlike any other STD, AIDS is not only a health problem, it is a political and legal problem. Laws regarding confidentiality, informing the

sexual partners of infected persons, antibody testing, and discrimination are quite explicit in several states. Counselors, educators and therapists must be familiar with the laws in their states and communities and must understand the liability implicit and explicit in those laws.

Another consideration under AIDS legislation is how legislation effects the medical management of the epidemic. The balance between the preservation of individual rights and the preservation of public health is a precarious one, and a "hot" political issue. Sex educators, counselors and therapists should actively participate via their political representatives in developing laws that are sensitive both to individual rights and public health, and that do not cripple efforts to halt the spread of the disease.

F. Informing sexual contacts of HIV infected persons: What ethical responsibility does the therapist, counselor or educator have to inform the sexual contacts of an HIV infected person that he/she may have been exposed to the disease, and so may be infected and infectious? In most states, the sexual contacts are not informed by the public health department, and some states have laws prohibiting informing anyone except the patient of the results of an HIV test. The therapist faces an ethical dilemma, as well as a legal issue, in this case. How is the confidentiality issue handled when a therapist knows that an infected patient is behaving in such a way as to

jeopardize the life of another?

In California, it is against the law to inform even a spouse without the written consent of the patient who has AIDS or is AIDS antibody positive. Some therapists are relying on the Tarasoff decision (see enclosure) that requires a therapist to inform a potential victim if their life is threatened to break confidentially and inform sexual partner(s) who are being unknowingly exposed.

G. Safe Sex Guidelines: Therapists, counselors and educators must be very careful regarding how they define and describe "safe sex" practices for three important reasons.

1. The wrong information can result in your patient or student contracting a fatal disease.
2. Misinformation can result in the spread of disease to others.
3. Eventually there will be law suits filed against those whose advice has resulted in disease. The potential liability is great.

For example, the issue of condoms and spermicides as safe sex measusres is controversial. Many authorities are recommending them for protection because laboratory experiments have shown they do not pass AIDS virus, herpes virus or sperm. However, in practice, (see enclosure) condoms have a 10% failure rate for pregnancy - spermicides a 16% failure rate. Two women

whose infected partners used condoms to protect them became antibody positive (see enclosure). Will the physicians who advised these couples to use condoms experience legal repercussions? Or did they protect themselves and their patients by informing them that there was still some risk.

For many reasons, one must be very conscientious in making "safe sex" recommendations. Barrier methods and spermicides are helpful, additional protection, but shouldn't be considered any safer in the prevention of AIDS than in the prevention of pregnancy.

What guidelines can you give to your clients, patients and students? How can you break through their denial systems, and even your own? How can you protect their interests and those of society as well? These are the challenges.

In the spectrum of safety from living in a bubble to having multiple partners without concern, where does wisdom lie?

Celibacy and masturbation are risk free. Monogammy with a monogamous partner who is not already infected is safe, except that many partners are not trustworthy and the trusting one is often the last to know. Sex using condoms and nonoxynol-9 spermicide offers some protection but not complete safety. Sex without condoms that is not monogamous is not safe.

What you can do:

1. Advise clients, patients and students that sex with

an uninfected partner is safe. Absence of infection cannot be guaranteed or proven over time. A blood test can be obsolete the next day if partner has sex with someone who is infected. Share these facts. Encourage exclusivity and trustworthiness.

2. If your patient chooses to continue to have sex on a casual basis or with more than one partner, recommend the use of condoms and spermicide, but inform them of the risk.
3. Learn social skills and dating skills that include when and how to address the issue of STD's, AIDS and best methods of protection.

Also please feel free to write the AIDS Task Force, c/o The Crenshaw Clinic, 550 Washington St., Suite 723, San Diego, CA 92103 with any comments, questions or problems you are facing so that we can address them in future editions of these guidelines.

Enclosures: 1) WHO article

2) Condom failure rate

3) 2 Cases condom leaks

4) Condom not reliable

5) Tarasoff issue

sexuality today

The Professional's Newsletter on Human Sexuality

Volume 10, Number 2 October 27, 1986

Does Tarasoff Obligate Therapists To Warn Sexual Partners Of Their Clients Who Test Positive For AIDS?

Sexuality Today recently reported on the dilemma of a therapist in a Veterans Administration hospital whose client had tested positive for the AIDS virus. That client was now interested in engaging in heterosexual relationships, including sexual intercourse with his new partner(s).

Telling the client not to engage in sexual intercourse without informing his partners that he has tested positive for the AIDS virus may not be enough. In a recent follow-up call, the therapist informed *ST* that the VA hospital lawyer has told him that the "Tarasoff decision" applies in the latter case. According to the lawyer, a therapist has an obligation to warn any known sexual partners of his client that he has tested positive for the AIDS virus. "I must now inform my client that if he identifies any sexual partner, I will be obliged to tell that person about his testing positive for the AIDS virus," the VA therapist told *ST*.

ST discussed this issue with marriage and family therapist, Dr. Harvey Hester, Southeast District Leader, AASECT (American Association for Sex Educatiors, Counselors and Therapists) who reported on a recent case in which a married male client decided to take the test for HTLV-III. In this particular case, the wife was unaware of her husband's homosexual activities. When Hester asked him whether or not he would tell his wife should he test positive, the client said that he would not do so. Hester then told him, "If you test positive, I will tell your wife.

"I believe that I have an ethical and moral responsibility to inform sexual partners of those who have tested positive for the AIDS virus that this is the case." Hester admits that in so doing, he could lose that client, but feels that ethically one must do so anyway. "There are a number of issues involved, not just that of confidentiality and trust. There is also the issue of autonomy. Certainly, someone who finds out that he has tested positive for the virus will feel a great deal of anger. And, it is possible that he may decide that, under the circumstances, he doesn't care how many partners he may infect. Telling him that you will be obliged to warn those sexual partners he mentions in therapy, may very well cause you to lose that client, but I don't think that you have any alternative but to do so."

Let us know how you are handling this dilemma.

Contact: Dr. Harvey Hester, 145 Aurora Rd., Melbourne, FL 32935, 1-305-259-6239.

Centers For Disease Control Still Ignorant About Extent of HTLV-III Infection In Children

In the period June 1, 1981 to September 2, 1986, physicians and health departments in

U.N. Agency Begins Global Push on AIDS

By Lawrence K. Altman
New York Times

United Nations

The World Health Organization announced yesterday that it has begun the first coordinated worldwide attempt to combat AIDS, a disease it described as "a health disaster of pandemic proportions."

The organization is elevating the fight against acquired immune deficiency syndrome to a status equivalent to its programs to combat entire groups of tropical diseases and to promote childhood immunizations, said the leader of the World Health Organization, Dr. Halfdan Mahler at a news conference here.

He said that the organization, a

Page 18, Col. 3

San Francisco Chronicle Friday, November 21, 1986

U.N. Agency Attacking AIDS on a Global Basis

From Page 1

Geneva-based agency of the United Nations, also is giving the AIDS effort the kind of backing it gave to the eradication of smallpox. He said that the organization hopes to be raising $1.5 billion a year by the 1990s for the fight against AIDS.

"We're running scared," said Mahler. He said he could "not imagine a worse health problem in this century."

"We stand nakedly in front of a very serious pandemic as mortal as any pandemic there ever has been. I don't know of any greater killer than AIDS, not to speak of its psychological, social and economic maiming," he said.

In an interview, Mahler made an unusually candid admission — that he had originally not taken the disease seriously enough. "Everything is getting worse and worse in AIDS and all of us have been underestimating it, and I in particular," he said.

He said a year ago, at a news conference in Zambia, that people should keep AIDS in perspective to other diseases. Yesterday he acknowledged that he had not had "a feeling for what was brewing with regard to AIDS."

Mahler said at the news conference that 100,000 people have come down with AIDS worldwide, according to reports by governments and extrapolations by WHO. One million people have AIDS-related disorders, he said, and up to 10 million are infected with the AIDS virus and presumably are capable of spreading it.

He said that as many as 100 million people could be infected with the AIDS virus in five years.

Mahler also said that AIDS is "knocking unpleasantly on the doors of Asia" and that if it becomes a major problem there, the estimate of its potential spread could rise.

In the United States, the Public Health Service has predicted a total of 270,000 AIDS cases by the end of 1991, including 179,000 deaths. Scientists now estimate that for those who do come down with AIDS itself, the average lag time between infection with the virus and diagnosis of the disease may be five years or more.

Mahler said the AIDS program would include these points:

■ Providing model policies and strategies for combating AIDS, chiefly through educational campaigns, in every country that requests help.

■ Expanding a global information-gathering system to screen and disseminate information to health workers. An attempt will be made to help countries benefit from educational programs that have proved effective elsewhere.

■ Creating an international network among scientists to share information, and a far more aggressive program of research into drugs, vaccines and other therapeutic and preventive health measures.

■ Tapping the skills of sociologists, behavioral scientists, communications experts and others outside the traditional boundaries of public health professions.

■ Educating health workers about how AIDS spreads and about the dangers of repeated use of needles without sterilization between injections, a common practice in Third World countries.

Dr. Jonathan Mann, an American researcher who has spent two years working on AIDS in Zaire, will be the head of WHO's effort.

Continued From Page 1

active residents of the inner city face the greatest immediate danger. Nowhere is this threat greater than in New York and northern New Jersey, where dirty needles are a constant conduit of AIDS.

Up to now, most heterosexually infected AIDS victims have been the partners of heroin addicts, and most have been black or Hispanic women. This explains why four out of five children who developed AIDS after being infected at birth have been black or Hispanic.

Minority teen-agers and young adults in urban areas already suffer the country's highest rates of venereal disease, observes Dean F. Echenberg of the San Francisco Department of Health. Add in the high incidence of drug abuse and this group seems "ripe for a wildfire heterosexually spread epidemic of AIDs," he warned.

Last week scientists and health officials at a conference, sponsored by the Montefiore Medical Center in the Bronx, on the heterosexual transmission of AIDS agreed that the public at large must be alerted to the rising hazards of unprotected, promiscuous sex. No one dissented when Mervyn Silverman, director of the American Foundation for AIDS Research, said educators should talk "less about risk groups" and "more about risky activities." All applauded New York City's Health Commissioner, Stephen C. Joseph, when he declared: "The day of the condom has returned."

Prevention Among Drug Addicts

But preventive efforts must focus with special intensity, most experts agreed, on intravenous drug addicts and their sex partners, the primary sources of AIDS infection among heterosexuals. No effective attack has been mounted on the spread of AIDS by shared needles.

Health experts also caution against any relaxing of preventive education about "safe sex" among homosexual and bisexual men. Although half the homosexuals in a few cities may already be infected, a majority nationwide are not and some, especially men who only occasionally engage in homosexual acts, may not realize the exceptional danger.

Excluding immigrants from Haiti and Africa, where heterosexual transmission of AIDS is common, the proportion of American AIDS cases clearly traced to heterosexual intercourse is 2 percent, up from 1 percent in earlier years of the epidemic. Four out of five of these patients are women.

When cases among immigrants are counted, the total share of the country's cases attributed to heterosexual contact is 4 percent.

Only a few American AIDS cases have been linked to infections passed along from partner to partner until none has any reason to suspect possible exposure. Such an extended spreadof the virus may, however, account for some of the 3 percent of cases with no explained cause, said Dr. Harold Jaffe, chief of AIDS epidemiology at the Federal Centers for Disease Control.

traced to homosexual contact or drug use and the proportion attributed to heterosexual relations was "minor" and "not different from normal," reported Mary Ann Chiasson, an epidemiologist at the Health Department. A new survey is planned, she said, for AIDS infection rates among people who visit a clinic for sexually transmitted disease and who agree to blood testing.

Studies Raise Puzzling Questions

Three new studies have highlighted the risk of unprotected intercourse with a virus carrier. They also raise puzzling questions.

Two of the studies, one involving 58 couples at the University of Miami and one of 93 couples at Montefiore, found that half or more of the steady, long-term heterosexual partners of AIDS patients, partners who faced no other discernible exposures, were also infected. The virus seemed to pass as readily from women to men as the reverse, and ordinary vaginal intercourse was a sufficient means.

During the Miami study, 16 AIDS patients continued, despite doctors' warnings, to have unprotected intercourse over periods ranging from one to three years. Thirteen of their partners became infected, for a transmission rate of over 80 percent.

Of 12 AIDS patients and their partners who continued having sex but used condoms, the infection spread in two cases — a far lower rate but still, given the presumed safety of condoms, a "very disturbing finding," observed Dr. Margaret Fischl, the study director. In both these cases the virus spread from man to woman, and Dr. Fischl speculated that oral sex involving semen discharges might be to blame.

A Curious Disparity

These and other studies found dramatic, unexplained differences in the rate of sexual spread depending on how the first partner had become infected. The virus was passed through intercourse far more readily from drug abusers than from people exposed by contaminated blood products.

Reinforcing this curious disparity, a study of 73 spouses of transfusion-associated AIDS victims found that only 5 percent of men and 16 percent of women acquired the virus through sexual intercourse over time. In this, as in the other studies, why the virus spread within some couples and not others was a mystery. Transmission was not correlated with frequency of

Condoms may not prevent AIDS transfer, expert says

UNITED PRESS INTERNATIONAL

LOS ANGELES — The use of condoms does not eliminate the possibility of getting AIDS through sexual activity, a medical researcher says.

In an article that appeared in the British Medical Journal last week, Dr. Bruce Voeller of Los Angeles said the condom has no proven value in preventing the transmission of sexually transmitted viral diseases — including acquired immune deficiency syndrome.

"This is the first time anyone in scientific literature has spoken out on the limitations of condom usage in preventing the AIDS virus," said Voeller, who is a co-author of the article.

"The Consumers Union reported laboratory testing of American brands of rubber and skin condoms and found significant leakage in some brands," the report said. "The Consumers Union also reported variable degrees of deterioration in a third of the 21 rubber brands tested."

"Health institutions have been telling people, 'for safe sex, use a condom.' Our point is that while the condom gives a measure of protection there is no research to show the exact protection," Voeller said in a recent interview.

Voeller, president of the Mariposa Foundation in Los Angeles, a medical research institution, said sperm are many times larger than any known virus, including the AIDS virus. He said if the accepted failure rate for condoms when used for the prevention of pregnancy is 10 percent, the failure rate for the prevention of AIDS would be considerably higher.

condom failure

Voeller said adequate brand testing studies of condoms should be conducted.

"If your life depends on how safe a particular brand of condom is, wouldn't you want to know its effectiveness?" he said.

Voeller also said instruction in correct usage of condoms is important.

"Even though we believe that condoms afford a substantial degree of protection and their use should be encouraged, that encouragement should be tempered with cautionary warnings discouraging increased sexual activity," the report said.

The co-author of the study was Dr. Malcolm Potts, director of Family Health International in Research Triangle Park, N.C.

San Francisco Examiner 11-7-85

S.F. has 60 new AIDS cases, 43 deaths

UNITED PRESS INTERNATIONAL

Sixty new cases of AIDS were diagnosed in San Francisco in October and there were 43 AIDS-related deaths, the city Department of Health reported.

A spokesman said yesterday the number of deaths from acquired immune deficiency syndrome reported during the month was 10 more than in September, although the number of new cases reported declined slightly from September's figure of 62.

Since July 1, 1981, San Francisco has recorded 1,499 cases of AIDS and 784 AIDS-related deaths, roughly 1 percent of The City's population. The totals for 1985 are 629 new cases and 382 deaths.

1986

Table 2. Percentage distribution of women who discontinued IUD use between January 1980 and the NSFG interview date, by exposure to the risk of unintended pregnancy and contraceptive use at time of survey

Status	All women	Women at risk
Not at risk	37	na
Pregnant, postpartum, seeking pregnancy	21	na
Noncontraceptively sterile	10	na
Not sexually active	5	na
At risk	63	100
Using a method	54	85
Sterilization	28	45
Pill	14	22
Condom	3	4
Diaphragm/spermicides	9	14
Periodic abstinence	0	0
Other	*	*
Using no method	9	15
Total	100	100

*Less than 0.5 percent.

Note: na = not applicable.

In the following section, we attempt to quantify the effects that changes in method use might have on the risk of pregnancy among current IUD users. The analysis takes as its starting points the patterns of method use found among women who have already stopped using the IUD, the fact that only 44 percent of current IUD users are candidates for oral contraceptives and the fact that 55 percent of IUD users say that they want no more children.

Table 2 shows the distribution of women who discontinued IUD use between January 1980 and the NSFG interview date (late 1982 or early 1983), according to their method use at the time of survey. At that time, 37 percent were no longer at risk of unintended pregnancy because they were pregnant, postpartum or seeking pregnancy; because they had become noncontraceptively sterile; or because they were not sexually active. The other 63 percent probably offer the best indication of what current IUD users forced to discontinue their method might do, since it is fecund women at risk of pregnancy—not women who are pregnant, seeking pregnancy or postpartum—who would normally be using this method.

Among the women still at risk, 45 percent had chosen sterilization of themselves or their partners—an unsurprising finding, given the large proportion of IUD users who say that they want no more children. The next largest contingent of former IUD users, 22 percent, had switched to the pill, the most effective reversible contraceptive. Fourteen percent had adopted the diaphragm or spermicides, and four percent had adopted the condom; but 15 percent were using no method.

Table 3. Percentage of married women who experience a pregnancy within the first year of contraceptive use, by method used

Method	%
Sterilization	0.4
Pill	2.1
IUD	4.2
Condom	9.8
Diaphragm/spermicides	16.3
Periodic abstinence	21.2
Other	10.6
None	65.0

Note: Except for sterilization, rates are based on women aged 26–29 who had family incomes of $10,000–$15,000.

Sources: **Failure rate for sterilization**—H. W. Ory, J. D. Forrest and R. Lincoln, *Making Choices—Evaluating the Health Risks and Benefits of Birth Control Methods*, The Alan Guttmacher Institute, New York, 1983, Figure 2. **Rates for other methods**—see reference 21. Rates shown here are averages of the rates for women seeking to prevent pregnancy and the rates for those seeking to delay pregnancy.

The Risks of Changing Method

To the extent that women switch from the IUD to an even more effective method, they will face a lowered risk of unintended pregnancy, whereas they will face an increased risk if they choose a less-effective method or no method at all. We use the pregnancy rates shown in Table 3 to estimate the effect of movement from the IUD to other methods. For all methods except sterilization, these rates are based on women aged 26–29 who have annual family incomes of $10,000–$15,000, and represent the averages of the rates among women seeking to delay and those among women seeking to prevent a future birth.[21] Use of these criteria, we believe, reflects somewhat more closely the actual characteristics of current IUD users (the largest proportion of whom are in the 25–29 age-group) than either the failure rates of all current users,[22] or the rates standardized to the age, income and pregnancy-intention distribution of all women using a method;[23] we have based the rates for the other methods on the same criteria, in order to use failure rates of women comparable to those using the IUD.

The pregnancy rates shown in the table are first-year failure rates per 100 woman-years of use. However, failure rates for the IUD decline with increasing duration of use,[24] and four-fifths of IUD users have used the method for more than one year.[25] In changing methods, moreover, IUD users would be starting the first year of use of a new contraceptive. Thus, the pregnancy rate used here for the IUD is probably somewhat high relative to the other rates. As for the one-year pregnancy rate associated with use of no method, the 65 percent shown in the table represents an educated guess; the figure commonly used for sexually active nonusers —86 percent[26]—seems to us too high, because of the relatively older age (though proven fecundity) of most IUD users.

To assess the effects of IUD discontinuation on the level of unintended pregnancy risk, we compare three possible scenarios of subsequent contraceptive practice by IUD users with a baseline estimate of the 4.2 percent annual pregnancy rate that could be expected if IUD availability were to stay the same. The results are shown in Table 4.

Scenario 1 assumes that current users move to the most effective methods possible—that is, all those who want no more children become sterilized (55 percent), those who want more children and can use the pill do so (30 percent—not shown), and the remaining 15 percent rely on their partners' use of condoms, the next most effective method. The resulting overall failure rate would be 2.4 percent per year, or about 60 percent of the level to be expected if all current IUD users stayed with their method.

Scenario 2 recognizes that although sterilization may be a sensible option, many IUD users are not yet ready to choose it. Instead, the scenario assumes that all those who can use the pill adopt it (44 percent); that three-quarters of those who cannot use the pill select the diaphragm or spermicides (the next most effective methods whose use is controlled by the woman); and that one-quarter are protected by condoms. Such changes would be associated with a combined annual failure rate of 9.2 percent, or more than twice the pregnancy rate of IUD users if they made no change.

Scenario 3 represents what is probably the most likely course of events. This option assumes that the post-IUD pattern of contraceptive use will be similar to the pattern observed among women who discontinued IUD use in 1980–1982 and remained exposed to the risk of unintended pregnancy (see Table 2). The pregnancy rate under this scenario is very high—13.0 percent, or three times the rate otherwise expected. Three-quarters of the resulting unintended pregnancies would be contributed by the 15 percent of women not using any contraceptive.

The implications of the three scenarios make it clear that women who no longer have access to the IUD must make some difficult choices. Sterilization entails the lowest risk of pregnancy; but 45 percent of current IUD users say they want another child, and at least some of the remaining 55 percent may not be ready for this final step. Already, 10