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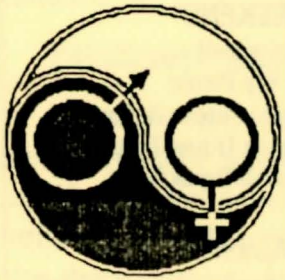

ALTERNATIVE LIFESTYLES: MARITAL OPTIONS

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Introduction

The following article appeared in Lifestyle Management. It is a well chosen article for its importance in helping professionals who work in the field of CD/CG Behaviors. The author is an active therapist, sex educator and counselor in the Greater Philadelphia Area. The article is reprinted here with his permission. (Ed.)

Overview

Thirty years ago there were few sexual lifestyle choices that were considered valid. Either you got married, or if it was your vocation, you became a priest or nun. Anything other than marriage was considered as going against home, family,and religious and national heritage. Certainly, if you never married, you could expect to be pitied. Today it is a different world. Our children and indeed even we ourselves have many lifestyle choices, any one of which is

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considered legitimate by some section of our society, and it is a fact that in this latter part of the 20th century a large proportion of Americans are feeling free to choose from this wide variety.

Sexual lifestyle, for the purposes of this chapter, refers to the relational patterns around which individuals organize their living arrangements, and shall henceforth be termed simply as "lifestyle." (Sometimes the term "lifestyle" is confused with the term "sexual orientation." The latter refers to a person's individual preference in erotic patterns -- what "turns a person on.") These lifestyles can be heterosexually, homosexually, or bisexually oriented. Many contemporary women, men, gay persons, young people, married couples, single adults, and older people are pioneering by living in nontraditional ways.

Unfortunately, most clinicians are not trained to work with persons living alternative family lifestyles. Most training in marital and family therapy is based upon a traditional monogamous nuclear lifestyle. It is the experience of many if not most clinicians that the traditional monogamous nuclear marriage is now a minority lifestyle. What about other marital and family styles? How can the clinician be better informed and better trained for more creative therapeutic interventions? In this article the concepts behind some of these choices will be explored, as well as the types of lifestyles that Americans are choosing today, and special consideration will be given to the clients and the therapists who are dealing with these choices.

Psychopathology and Alternative Lifestyles

There are those professionals who will read this chapter and immediately come to the conclusion that what is being discussed is a manifestation of neurotic conflicts regarding intimacy issues and disturbed object relations. They may or may not be correct. There are also those professionals who are such advocates of alternative lifestyles that they will read this article and proclaim how healthy it is

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that more and more people are breaking the bonds of traditional lifestyles and developing relational patterns that are more fulfilling to them. The latter group too may or may not be correct. Speaking to both of these groups of professionals, I would make the following observations.

First, the lifestyles mentioned here are neither being advocated nor disavowed. They are all lifestyles that are being chosen by large numbers of people. What is being offered is a description of the various lifestyles, some statistics if they are available, and occasional examples from my own private practice as a marital and family therapist. Second, there is certainly no unanimity among the various professionals in education, therapy, or research as to what is or is not a healthy lifestyle. If each lifestyle could be dissected there would still be diverse opinions as to whether it is healthy or not.

Third, there can be healthy or pathological aspects in any of the lifestyles. Each person or system has to be evaluated individually. Although there are no statistics available, there is probably no more pathology, proportionately, among the alternative lifestyles as in the more traditional lifestyle of the monogamous nuclear family.

Monogamy

One of the most important issues that arises in the process of analyzing and understanding the various choices is that of monogamy. Prior to the 16th century most Western philosophical and religious thinkers were not interested in lifestyle choices, especially within marriage. Today however such choices are a matter of major importance and concern. Pickett (1978) found that practically all cultures have had alternatives to monogamy which were usually reserved for the elite or upper-class citizens. Monogamy was usually prescribed for the lower and slave classes as a way of controlling them. It may be that monogamy is not natural for all people, which could account for the fact that so many people are not monogamous. My purpose is not to challenge monogamy nor to make a value judgment regarding it, but rather to point out that for many people in our society monogamy is not an important issue. Certainly our divorce statistics today indicate commitment to marriage as an institution but not to "lifelong" monogamy.

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Most couples marry with the expectation and hope that each will be able to meet the other's needs as a partner, friend, and lover. Each goes into marriage wanting and making a commitment to fidelity. Since the terms "fidelity" and "infidelity" can be defined in many ways and can include many facets of a relationship other than sexuality, for our purposes we will limit this discussion to sexual fidelity and infidelity and we will assume that maintaining a healthy sexual relationship is of primary concern to most couples entering marriage.

It is likely that many who make the commitment to sexual fidelity (monogamy) will not adhere to that commitment throughout their marriage. Couples react differently to changes in commitment; thus, it becomes important to define when a couple is involved in sexual infidelity.

First, there are couples who for various reasons change their commitment to sexual fidelity. They may decide that they want a sexually "open marriage." Thus, the commitment changes so that when one or both spouses become involved sexually with another person, they are not involved in sexual infidelity because they are not violating a commitment to each other. New agreements had been made before new behaviors began.

Second, there are couples who make allowances for certain types of sexual expression outside of marriage. For example, one spouse may want his or her partner to remain sexually exclusive while at home, but will make allowances for the partner to experiment sexually while at a conference or business meeting away from home. Or one or both partners may want certain agreements such as "just don't tell me about it." As long as the partners hold to that agreement, it

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cannot be said that the couple is engaging in infidelity (even if they have "one-night stands" while away from home) because they are being faithful to their mutually agreed upon commitment.

Third, there are couples who through the years place a high value on sexual exclusivity and who do not want or intend to break their commitment to sexual fidelity. Many couples have the expectation when they marry that they will always completely satisfy one another's needs and will never be attracted to any other person. However, sexual attraction to other persons probably occurs no matter how much in love one is with one's spouse. If couples believe that sexual attraction is akin to sexual infidelity, then just the feeling of attraction can be a real threat to the marriage even though neither partner acts upon that feeling.

Persons and relationships inevitably change. Thus, it is important for couples to understand that their relationship will most likely change over time. The most critical changes occur in a couple's communication patterns, their sexual relationship, and in their experiences of feelings of closeness and intimacy with one another.

Representative Value Systems

As a clinician, the most important issue that I uncover while working with persons regarding lifestyle choices is that of values. It is important then for clinicians to be able to listen, hear, and know the people we are serving since our clients represent a variety of value systems and, for them, their values make rational what may appear irrational or even inappropriate to others. As a therapist it has been helpful for me to begin to understand these value stances, to appreciate them, and to know that they are sacred to the people holding them. By outlining the various value stances, one can more easily understand some of the underlying motives for behavior choices. Working with people from various value stances has also confronted me, both as a person and as a clinician, with my own prejudices and values.

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A client, struggling with an alternative lifestyle issue, has at least five major concerns to consider. It is best if the client can sort these through before entering therapy. However, this is not the way it usually happens.

1. If therapy is a choice, a major consideration is finding a therapist who can be trusted to not be judgmental about lifestyle desires or choices. All too often people enter therapy not sure of what the therapist believes and thus they may or may not divulge real information about their lifestyles. A large number of clients have come to me after having had one or more therapists whom they could not trust with their lifestyle information. After talking with the therapist for a few sessions they knew the therapist's values and probable judgments.

   It is a sad commentary that a person or couple can be in therapy -- perhaps for years -- and not feel free to tell the therapist about their lifestyle. I have also had clients who told their former therapists about their lifestyle choice and had the therapists spend many sessions trying to no avail to help them change their values regarding that choice.

   My own approach has been to accept almost all lifestyle choices as valid. My criteria for validity include choices that are freely made, among consenting adults, without any form of coercion, and that are within the value systems of those involved. I have found that if there are strong, neurotic reasons behind the lifestyle choice, these come out in the normal course of therapy, and I handle them as therapeutic issues, much the same as if the person has a traditional lifestyle. The end result could be a change in lifestyle choice -- but not necessarily.

2. The client needs to be aware of his or her own value stance regarding lifestyle choice.

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3. There is a need to explore the value stances of others, both directly and indirectly, involved in the lifestyle choice.

4. The psychodynamics of all the persons involved in the lifestyle need to be understood and dealt with as part of the problem-solving process.

5. The values of society and the impact of those societal values on the lifestyle choice need to be understood and appreciated.

Therefore, the values of therapist, client, others involved in lifestyle choice, and society must all be taken into consideration in helping persons with lifestyle issues.

In America, we basically have three types of value stances (Stayton, 1981). These are important for clinicians to understand so that they can know where both therapist and client are coming from when working on lifestyle choices. Two outstanding pioneers in the field of human sexuality have influenced by thinking in this area: Lester A. Kirkendall (1977) and James Schulte (1981). I have tried to integrate their concepts regarding values and have created a paradigm that has been useful for me both in teaching and in therapeutic sessions with persons in alternative family forms (see table 1). Because the subject of values is so emotionally loaded, I am going to use Systems A, B and C to designate the categories in order to be as fair as possible to each one.

TABLE 1 Representative Value Systems

Value System	A	B	C
Focus of concern	Acts		Relationships: Motives and consequences
Location of authority	External		Internal
Moral responsibility	Detached/aloof		All involved
Purpose	Tradition		Promote growth
Reward	Divine favor		Meaningful life

Source:Adapted from Lester A. Kirkendall (1977) and William Stayton (1981).

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System A is the value stance with which most Americans are probably familiar. It could be considered a traditional view because it is the "official" stance of most religious groups and even of our society today. It is "act" centered. There is something inherently good or bad, moral or immoral, healthy or unhealthy about any act including the various forms of sexual expression involved in lifestyle choice. Thus, in System A any non-marital sexual act would be considered wrong, immoral, or unhealthy because the act itself is at issue.

On the opposite end of the value continuum would be System C, which is "relationship" centered. Here, good and bad, moral and immoral, healthy and unhealthy are seen in connection with the motives and consequences of the act rather than in the act itself.

This value stance is exemplified by a couple I saw who had been married for more than 40 years. The wife was diagnosed as having multiple sclerosis (MS) shortly after their marriage. In obtaining information on the disease the couple discovered that sexual apathy would be a symptom as the illness progressed. They discussed this in depth over many months and even though they were very religious, they decided that a way they could combat the apathy and its effect on their relationship would be to open their marriage to include other sexual partners. For over 35 years they have had an open marriage and each has had a number of significant partners. Interestingly, the wife has been free of MS symptoms for that same amount of time. They both attribute her symptom-free years, their good sex life, and their strong marriage to the openness they share. Becoming active in a liberal church tradition has helped them to work through their own values regarding their lifestyle choice. Forty years ago their pastor helped them to look at their motives and consequences and to develop criteria for making their decisions based on what would build love and trust, enhance communication, and encourage cooperation and mutuality. After weighing all the above factors they chose an open marriage.

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A second dimension in regard to values is the location of the authority for those values. Under System A the location of authority has been external; for example, "God says" or the "Bible says" or the "law says" or "Freud says" or "such and such authority says" are quoted to give credibility to the stance. Under System C it is believed that the location of authority really has to be internal -- one's own sense of authority.

As psychotherapists, part of our task in working with individuals, couples, and families is to help them to sort out all the issues around their value concerns and to come to their own decision -- their own internal sense of authority. They will take the responsibility for what is right or wrong for them after examining their motives and the consequences of their decision. Regarding nonmarital sex, there are many authorities who represent the spectrum of viewpoints about this issue. There are the precepts and concepts of a particular faith group or religious denomination, the perspectives of experts in the field of individual psychodynamics, marriage, and the family, the official positions of organizations such as the Sex Information and Education Council of the United States (SIECUS), the laws of the various states and the nation, and the personal authorities from each person's background. Based upon the information these resources offer, persons are urged to come to their own conclusions and to make up their own minds concerning what is right and responsible for them. Thus persons from System A or System C can be guided through this process and both will feel more secure about their decisions regarding lifestyle.

The third dimension to consider regarding values is where moral responsibility for a person's actions lies. Moral responsibility under System A derives from a detached and aloof position. Usually, a person who is in authority tells a person who is not in authority what is right or wrong, healthy or unhealthy. The detached, aloof authority figure may never have had to struggle with the issue on a personal level. Those in System C proclaim that moral responsibility is something that involves all of us. The moral climate of a family, a couple relationship, or the alliance between therapist and client are processes that all share equally. Moral responsibility, according to System C, is not something one can remain detached from while proclaiming the moral irresponsibility of others who make lifestyle decisions that do not agree with the external authority's preferred choice.

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A couple came in to see a therapist. The husband turned to the therapist and said, "My wife has been having an affair with our neighbor for five years. I have been a good husband. I have never gone outside our marriage for sex. I get up early every morning and after jogging a few miles, I go to work and work hard trying to make enough to keep this family in a comfortable lifestyle. I get home at about 10 P.M. every night and now I find out that she has been sleeping with our neighbor all these years. Fix her up!" This husband is a good example of a System A person. If the therapist is also from System A, he or she might be judgmental about the affair. A therapist from System C; would regard the husband as being just as responsible for the affair as the wife herself. The latter therapist might even view the affair as understandable because the husband was never around and he was detached and aloof from the wife's need for companionship.

The fourth dimension of a value is its purpose. Under System A the purpose of a value is to maintain a tradition. If that tradition is to revere monogamy, then the purpose in helping couples to develop their marriage potential is to maintain that tradition. Persons in System C say that the purpose of values is whatever will promote their own personal growth as individuals, couples, or family. They say that values should help us to be better people. In fact, this group contends that the only reason we have values is to promote growth and not to maintain a tradition which may be obsolete. An example might be a couple who find no meaning in maintaining a monogamous relationship, but who find both their individual and

joint lives enriched through sexual sharing with other individuals or couples.

Finally, when looking at values, it is also important to consider the reward for holding a particular value. Some say the only reward for holding a particular value is Divine favor, or that a particular value is the "only" psychologically healthy alternative. Those in System C believe that the reward for holding particular values is that life can be lived more meaningfully in the here and now. Further, many believe that living a meaningful life now is fostering their health -- even though their choice is a non-traditional lifestyle -- because they have taken motives and consequences into account and they are continuing to grow to be better persons.

We will now turn to System B. This value stance probably represents the majority of persons in our society. Most often people in this group were brought up under System A and believe that it is important to maintain and teach this system of values, but when it comes to their own personal and very private decisions, they make these based on System C. They rationalize in some way that System A is just not relevant to them for a particular issue. An example of this occurred recently when a clergyman and his wife came to talk to me about their open marriage. He continued to preach and teach about monogamy as the only "right" value for members of his congregation, but privately felt that monogamy was not an appropriate choice for his marriage. Another example is the number of Roman Catholics who practice birth control, which is against official church doctrine, yet continue to attend the mass and partake of the sacraments. They believe that somehow the church doctrine regarding birth control is just not relevant to them personally. Persons in System B often move back and forth on different issues between Systems A and C.

People who seek a psychotherapist because of lifestyle choice and who are having difficulty with that choice are usually persons in System B, people caught between two opposing, incompatible systems. These are the persons who can benefit from therapy that helps them to sort out the issues and to make decisions regarding the marital style that will best foster individual and couple growth and fulfillment.

It is important therefore for the client to choose a therapist who can be helpful in sorting out the value issues. A therapist whose own values come from System A will probably not be helpful to many clients because most representatives from this value stance have difficulty tolerating other value positions. The therapist from System A who can tolerate other value stances and not be judgmental can be very helpful to persons who are struggling with Systems A and B. The therapist from System C, unless a crusader for that system, is usually able to be more nonjudgmental and tolerant of all the value systems.

Lifestyle Options

When considering the types of lifestyles people are choosing today, at least 14 possible lifestyles have been identified, although there is no consensus on the total number and variation. Those discussed in this section are to a great extent taken from a listing in The New Intimacy (Mazur, 1973), and have been observed in my own clinical practice.

Traditional monogamy. It is interesting that this traditional and societally upheld lifestyle is no longer the strongly predominant lifestyle in American culture. In fact, even the traditional family, composed of father, mother and children "accounts for only about a third of all U.S. households" (Nass, Libby & Fisher, 1981, p. 288). From various studies it is estimated that only approximately 30 percent to 40 percent of married couples in America continue in one monogamous relationship for life without having any secret affairs or one-night stands and with sexual fidelity as one of the most valued parts of the relationship (Kinsey, Pomeroy & Martin, 1948; Kinsey,

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Pomeroy, Martin & Gebhard, 1953; Athanasiou, Shaver & Tavris, 1970; Hunt, 1974; Tavris & Sadd, 1975).

Most couples who do marry do so believing that they will be faithfully married "until death do us part." The most serious threat to this lifestyle is not from without but from within, given the high rate of divorce and separation and the number of couples who turn to an alternative lifestyle later in marriage. But certainly we should not consider traditional monogamy on its way out as a viable lifestyle, as there are many who will continue to choose this pattern as a fulfilling and valued way of life.

As therapists we need to be careful that we do not make the judgment that sexual fidelity is the only healthy, correct marital lifestyle, or conversely, that sexual fidelity is an unhealthy marital lifestyle. There are therapists who will condone extramarital or comarital relationships when they and the couple believe that such relationships would be healthy for the marriage and/or one of the spouses. Criteria for condoning extramarital relationships might include such factors as a couple who does not experience jealousy or a sense of genital possessiveness, and who have a good and meaningful sexual relationship with each other. With these criteria met, if the couple desires to expand their marriage to include other sexual partners,the therapist might not be opposed. Another circumstance where a therapist might condone or even recommend an extramarital relationship is where the illness of one partner would preclude a meaningful sexual relationship such as mental illness or coma. (It seems to me that it would also be necessary that such actions be within the client's value system.) Therapists may also recommend that an extramarital relationship cease or not begin for the health of the marriage and individuals.

Child-free relationships. It is very difficult for most people who have children to understand those who decide against parenthood. There are a growing number of couples today who want to be in a

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long-term relationship but who feel that their lives will be more meaningfully fulfilled if they remain childless (Francoeur, 1982). Not many years ago, this decision would have been unthinkable. It was traditional that couples who did not have children were to be pitied and encouraged to adopt so that their "marriage could be complete." Marriage and parenthood have been synonymous in our culture. But those who choose a child-free lifestyle today are making the choice with valid and justifiable reasons. With the growing world population and nuclear warfare as real threats, couples do not feel guilty for not procreating. Other, more personal factors that can affect this decision are dual careers, the influence of divorce on the couple's own childhoods, and interracial and interfaith considerations. There are even materials available today to help a couple decide whether or not they would make good parents (Granzig & Peck, 1978).

Single parenthood. This lifestyle is very different from the "unwed" or "illegitimate" motherhood that I heard about so often as a young person. There are a good number of responsible members of our community today who are saying that, although they do not want to be bound in a permanent relationship, they do want the benefits of parenthood. Both women and men are choosing to raise a child or children without a partner in marriage. It is also true that single parenthood is a transitional lifestyle for many persons such as divorced persons. Many hope that they will remarry at some point in the future.

Today, at least one in every five children is living with just one parent. Interestingly, between 1960 and 1978 "children living with a separated parent doubled, those living with a divorced parent tripled, and those living with a never married parent were seven times the number they were in 1960" (Francoeur, 1982, p. 709).

No definite statistics on the number of never married men choosing single parenthood are available. However, it is not unusual to find ads in the personal columns of magazines or underground

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newspapers through which a man is seeking a woman to bear his child. Many fertility clinics have made their services available to single women who are seeking artificial insemination, a procedure that is safe and involves few legal complications. Some singles use terms like "elective parent" and "single parent by choice" to describe their lifestyle.

The fact that up to 50 percent of our school children come from couples who are divorced and live with one parent has contributed to removing the stigma of illegitimacy once associated with out-of-wedlock births.

Singlehood. Persons who do not marry are no longer considered second-class citizens. Words like "spinster," with its negative overtones have virtually disappeared from our vocabulary. At least 10 percent of our population will never marry. One third of all adults in America are single (Francoeur, 1982). This figure includes divorced,widowed, and never married singles. Marriage is not something many of these single persons avoid "as the plague," but is rather a state they choose not to enter for many valid reasons from career choices to being mobile and without family responsibilities. The Bureau of Census has reported that in the last dozen years the number of Americans aged 25 to 34 who have not married has doubled. While it is true that many of these persons will later marry, there is a definite trend toward staying single longer. In 1978, 22 percent of all households were made up of single persons. This represented an 8 percent increase over the preceding year (Nass et al., 1981).

Cohabitation. In this lifestyle two or more people live together in a relationship that is similar to marriage but lacks the legal ties. It has often been identified with college students. Indeed, several studies indicate that between 50 percent and 80 percent of college students would elect cohabitation arrangements if permissible on their campus, while probably up to 35 percent of college students are already in such a lifestyle (Nass, et al., 1981). Problems can occur

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when the commitment to this lifestyle is different for each person in the relationship. For example, one partner may see the commitment as one for the duration of the year or until graduation while the other partner considers it a part of the engagement period and expects that it will eventuate in marriage.

But students are not the only ones who choose this lifestyle. More and more couples in their middle and later years are now choosing cohabitation. In 1970, the Census Bureau reported one million couples living together; by 1977 this figure had grown to two million (Francoeur,1982). Many gay couples set up cohabitation agreements and contracts, representing for them the pattern closest to a legal marriage. Also, many senior citizens -- widowed or divorced -- opt for this lifestyle because of the financial disadvantages of marriage with respect to social security payments, and so on, and in order to avoid inheritance problems for the children.

As a college teacher and a clinician, I have noted two interesting phenomena. One is in the number of parents who are actually encouraging their youngsters to live together for a while before getting married. A reason often given is that marriage is meant to last for a long time and these parents want their children to be absolutely sure of the decision. There are parents who do not want their children to repeat their own mistakes by entering into a bad marriage or getting married for the reasons, and they think cohabitation may be helpful. The other phenomenon is the increasing number of persons who are cohabiting before entering into a second (or later) marriage. A reason often is that they want the choice to be right and responsible.

Serial monogamy. Most people who become divorced may want to remarry and many do. The trend, however, is that fewer are remarrying, and those who are take longer to make that decision (Glick & Norton, 1977). If they have been receiving marital therapy for the first marriage, they may have a better chance that the second marriage will be a happier and more satisfying experience although at present

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60 percent of second marriages also end in divorce (Francoeur, 1982). The majority of those who go from one monogamous relationship to another are however looking for one that is more mature and fulfilling than the previous one. While married, these persons are monogamous, and during their adult lives there may be a number of such marriages, thus, the term serial monogamy. As mentioned previously, a sizable number of this group will live together before remarriage.

Communes. Considering the kinds of ecological and economic crises we are facing today, one can understand the appeal of a communal setting. Thousands of communes have sprung up across the country during the last two decades or so. While we have tended to think of communes as a phenomenon of youth, today this lifestyle is more and more being identified with older people -- middle-aged and up. An entire book could be written on the different types of communes. People live together for many and varied reasons: professional, philosophical, political, therapeutic, religious, economic, or some combination of these. Participants can be single, married, divorced, or widowed. Communes are found at every level of society, economically and educationally. In the foreseeable future many people, in order to maintain the economic style of living to which they have become accustomed, may find the solution in communal living.

In the mid-1970s, a group of American Baptists, with encouragement from their denomination, lived communally near Philadelphia in a Roman Catholic abbey which was no longer in use. As a consultant to this group I felt involved in the life of this community. There were eight family units, from a one-person unit to married couples without children to married couples with children. The age range of the group was from 3 to the mid-50s. The community was interested in ecology as well as in building relational support systems among its members. They found that among them they had 12 automobiles; they needed only eight. Instead of eight refrigerators,

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washers, dryers and other appliances, they needed half that number when they began living together. They shared household chores which meant that each had less work than in their single-unit houses. Each family had its own private space as well as community space: a common kitchen, dining room, living room, playroom, and library. They ate one meal a day together, usually dinner; the other meals were fixed individually. (What amazed me was that in 1978, with their own garden produce and through buying in bulk, they fed their community for $7.50 per person per week, and they ate well. We could not feed our family of six on twice that amount.)

While there are some communes that include the sharing of sexual intimacies, this particular one did not. The community remained together until the Catholic order took the abbey over again. All of the members felt that the five-year experience had been a very valuable and significant part of their lives and, although the majority returned to their single-unit lifestyle, those I have talked to would live communally again under the right circumstances.

Swinging and/or group sex. Most men and women have probably fantasized about a sexual relationship with someone other than their spouse. Today a growing number of couples are making this fantasy a reality. There are estimated to be 10 million so-called swinging couples today, with national, state, and local organizations for them to join (Nass, et al., 1981).

Swingers are couples who meet other couples with the intention of pairing off for sexual and/or sensual experiences with someone new. Individuals and couples who do not belong to an organized swingers' group may join together as friends for sexual purposes. People who enjoy this lifestyle come from every economic, educational, religious, and racial group in our society. Most often these people lead conventional lives in every other respect. They consider sex a healthy, recreational pastime rather than a sin, vice, or indulgence in perversion (Francoeur, 1982).

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Contrary to popular myths, some research studies have found that swingers often rate their marriages as happier and more fulfilling than do those couples who have no other intimate relationships (Gilmartin, 1975). I have known several swinger couples, none of whom fit our society's stereotyped "far out" picture of such people, including a 70-year-old couple who have been married for 43 years.

While this sexual lifestyle may meet with disapproval in the population at large, it is important to remember that this is a mutually agreed upon lifestyle between the partners and it does receive support from other swingers. Swingers then have the advantage of an internalized ideology that considers their behavior both moral and desirable. The swinger couples with whom I have talked insist that they strongly value fidelity in their marriages, but they discuss fidelity in terms of an open, honest, and trusting relationship.

There seem to be at least three types of swingers: those who desire only sex with an outside partner, with no social or emotional expectations; the recreational swingers who see the social aspects of swinging as being as important as the sexual aspects and who often belong to private clubs with rather stable memberships; and finally, those who are seeking close and lasting relationships or friendships with their outside partners.

Group marriage. While heterosexual monogamy is the only legally accepted marriage, there are those in our society who are choosing to live in a marriage-type relationship involving three or more committed adults. Some group marriages are closed, in that sexual intimacy is kept within the bounds of the relationship. Others have an open contract that allows members of the marriage to have other outside sexual contacts. My first experience with group marriage clients -- two men and one woman who came to my office -- was very helpful to my understanding of some of the dynamics and pressures involved in this lifestyle. The woman and one of the men, legally married, met and subsequently became close friends with the

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second man -- close on almost every level: intellectual, emotional, social, and spiritual. And, as they described it, "it was a logical and smooth transition for our feelings of intimacy to be expressed on a physical/sexual level." They had their three-person union solemnized by a member of the clergy. Their purchase of a home together precipitated the twofold problem that brought them to me. First, because of their lifestyle, the neighbors had signed a petition against their living in that neighborhood. Second, one of the men was in danger of losing his job because his employer felt that his lifestyle would be offensive to the public his company served. The threesome wanted my help in learning how to build a greater understanding between themselves and those who were against them. They were very sincere about wanting to be creative in educating their critics.

As we worked together on their problem, I developed a real appreciation of their love and commitment to one another. They had no other outside sexual relationships but were committed to the idea of fidelity in their "marriage."

Synergamous relationship. I first read about this lifestyle concept in the book Thursday, My Love (Rimmer, 1972). The idea is that a couple involved in a primary relationship go on to develop a committed secondary relationship. The resulting secondary couple may even set up another residence where they spend time, which could be one day a week (as in Thursday, My Love) or one weekend a month, or one month a year. Ideally, the primary partner knows about and approves of the secondary relationship. Indeed, I have met several couples who have a synergamous marriage and find it to be a very meaningful arrangement. I have also known several couples where one or both of the partners is bisexual. These people have found a synergamous relationship to be ideal for their marriage since it allows the bisexual partner an opportunity to have a committed same-sex arrangement. In two of these situations the secondary relationship of one of the partners has been ongoing for several years and in each case the spouse knows and approves.

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Open-ended relationship in marriage. Some couples, although they want to be married, just cannot adjust to and be happy with a monogamous relationship. If both partners agree they may decide to enter into an open-ended marriage. In this arrangement both are free to establish other, independent, significant relationships. Sexual exclusiveness may or may not be part of the open contract. Open-ended marriage can be growth producing and successful for some couples, especially if they already have a strong and rewarding sexual and emotional relationship with one another. However, I have never known an open relationship to save a troubled marriage. This lifestyle has no place in a relationship that is characterized by jealousy and possessiveness.

McGinnis (1981) gives extensive data on extramarital relations. He has identified different personality and marital types and, based on given combinations, can predict whether or not a particular couple can have a successful open marriage contract.

Celibate marriage. It is difficult to know how many couples are living in a celibate relationship, but from my own clinical practice I know that it does exist. There are couples who have an otherwise excellent relationship but have no sexual desire or activity. A phenomenon often seen by the clinician is the madonna/whore syndrome. In this syndrome women are divided into two types. The madonna represents the woman who, held up and adored, is the person one marries and cares for but for whom one has no sexual desire or need (other than to have children) and whose model is the Virgin Mary. The other type of woman is whore, representing the woman of passion and sexual appetite, the woman who is sensual, sexual and seductive. If both partners view the married woman as "madonna" they are likely to develop a fulfilling celibate marriage after procreational needs are met. If only one partner exemplifies the syndrome, a celibate marriage may exist but without fulfillment for both partners.

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Celibate marriages may occur among couples whose high level of sexual activity in the beginning quickly deteriorates after marriage or after the birth of children. Negative reasons for a relationship becoming celibate are hostility, boredom, apathy, and depression. Such celibate couples would benefit from therapy unless both partners are happy with their arrangement.

Some persons choose a lifestyle of lifelong celibacy. Their reasons may be based on religious vows, as in the case of priests and nuns, or simply on the fact that they have never found a partner with whom they want to develop a sexual and emotional relationship. Other reasons for choosing celibacy include a fear of sexual intimacy or a lack of need for and/or interest in a sexual relationship.

Family network system. In this lifestyle, also known as the voluntary extended family, two or more family units join together as a way of sharing life's experiences (e.g., meals, vacations, special events), and as an emotional support system. In a world too often filled with loneliness and isolation, the family network system can fill a real need. Sharing sexual intimacy with other members of the network may or may not be part of the system.

It seems to me that fulfilling a supportive role was an original intention, sociologically, of our religious institutions. At one time the church or synagogue was the center of family life. It provided a support system for family members and was the center of social, cultural, educational, and recreational activities for the family. Today, in our highly mobile and compartmentalized culture, the church and synagogue have too often lost the feeling of the family network system. Thus, many families are reaching out on their own to establish and become a part of an expanded network that will help them to feel less isolated and alienated from others.

If I were to describe my own family's present lifestyle it would fit best under this category. Several years ago we joined with two other families, both of whom, like ourselves, had no relatives in the

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area. We established a family network system by having three evening meals together each week. On a rotating basis the host family prepared the meal and cleaned up afterward. We also share tools, help each other with some home repairs or maintenance, and often socialize together. Our particular network pattern does not include sharing sexually intimate relationships. It has been a rewarding experience and all of us have received a valuable support system in times of stress and crisis through the years.

The secret extramarital relationship. Finally, I add to the above list the seemingly monogamous relationship in which one or both of the partners carry on a secret affair. Several studies estimate that 65 percent to 70 percent of married men and 45 percent to 65 percent of married women engage in extramarital relationships at some time during their marriage (Nass, et al., 1981). The majority of these are secret and in general they are not helpful to the primary relationship. The amount of energy used to nourish the relationship and maintain its secrecy can rob the primary relationship of the kind of energy needed to keep it alive and healthy. This type of lifestyle is usually a forced choice and not a person's preferred pattern. Having chosen to participate in a secondary relationship, the person would prefer to be able to be open with her/his spouse. More often than in other lifestyles discussed, the person involved here is often filled with guilt and remorse and is not interested in dissolving the primary relationship. Secret affairs can consist of anything from a one-time experience to an ongoing and committed sexual relationship.

It is important to note, however, that in some cases the extramarital relationship is a possible outlet for a partner who may have a greater sexual need or capacity than his/her spouse or in cases where physical disability in one's partner precludes sexual activity. In a situation where the partner's sexual relationship is unsatisfactory, an extramarital relationship may give the involved partner important new insights into sexual communication and make possible an improved primary relationship.

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As a therapist I would not ever advocate the secret affair lifestyle to a client because of the secrecy factor. First, I have never known an affair to remain a secret. When the information does become known, the spouse sooner or later admits that she/he either knew, suspected, or at least was not surprised. It is very difficult, I believe, to live in an intimate relationship and keep an extramarital relationship a secret unless the communication between partners has totally broken down and they are virtually living separate lives anyway. Second, it is very difficult if not impossible to help a couple strengthen and grow in their relationship while one partner is maintaining an outside affair. Since many couples that I see are involved in a secret affair, one of the primary goals of therapy is to resolve how the issue of that affair will be dealt with in the context of marital therapy. If the affair is to remain a secret then the goals of increased intimacy and communication will need to be compromised. The therapist will have to decide in each case whether he/she will be able to work with that client system.

With the exception of this last lifestyle, I have tried to put forth the above alternatives without making judgments about them. There are moral and socially responsible persons to be found in all of them and, if we were to analyze the lifestyles of people we associate with in our everyday life, we would no doubt discover that many of these individuals have, at one time or another, been involved in more than one of these patterns. Thus, the lifestyles I have described are not mutually exclusive. One final thought. As a society we need to be more accepting of and open to the various alternatives that fit people's emotional, social, and sexual needs or desires. If these alternatives involve no inherent physical or emotional harm and no infringement on the rights of others, then it is my judgment that a chosen lifestyle has the right to exist -- as an individual's "typical way of life."

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Considerations of the Therapist

Just as I mentioned in the beginning of this article that a client struggling with an alternative lifestyle issue has major concerns to deal with, so too, in order to be helpful to a client, does the therapist.

First, the therapist needs to be clear about his/her own value orientation. If the therapist comes from System A, then it is very important for that therapist to be honest with the client about his/her value stance from the beginning. This therapist will generally not be accepting of any non-traditional sexual lifestyle. This person will believe that either for psychological or theological reasons nature intended human beings to live together in prescribed ways such as in a monogamous bonded relationship. Anything else would be considered either sick or sinful (or both). A couple coming from System B or C will be in conflict from the beginning with the therapist from System A.

If the therapist comes from System C, there is a better chance that the client will feel more comfortable in discussing lifestyle issues, even though the therapist may also believe that a monogamous nuclear marriage is the best of the options. Usually a person in System C will have considered the options and made a decision that for him/her a particular lifestyle was the best option. It would be just as important for a therapist from System C not to force any particular alternative on that client.

Second, in working with persons in alternative lifestyles, it is important that the therapist be nonjudgmental about lifestyles that may be nontraditional. This means that the therapist must work through his/her own belief system regarding monogamy. Therapy training programs have often espoused monogamy and marriage as the only truly healthy option. However, as many of the books in the references at the end of this article state, many people are capable of and successfully develop deep and intimate relationships with more than one other person. Contemporary lifestyle choices do not support

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monogamy as the only lifestyle suitable for humans, even though it may be the desired choice of the majority within a community.

Third, the therapist will need to clarify the value stances of those within the client system and try, in some way, to reconcile the differences. Sometimes I have found that by presenting the various value stances, the clients have gained a better appreciation of each other. They may find that their different value systems are irreconcilable. Thus, the therapeutic issue will be how the clients are to resolve those differences. The therapist's task is to clearly point out the differences and the values they represent. Hopefully the clients will be able to grow with the insights gained and then move toward a creative resolution of their conflict.

Fourth, the therapist needs to be at least academically familiar with the various lifestyle options. It is important to be able to point out the positive as well as the negative aspects of that lifestyle for each client system. The positive and negative factors will be different for each client. Part of this task includes putting societal values in perspective in terms of each client system. I have worked with several group marriages and two cases will suffice to illustrate this point. One group marriage consisted entirely of professional people who were involved in academia. There were four adults and three children. They were able to develop an acceptable living arrangement within their community because it was located in a large university section of the city where there were many known alternative lifestyle arrangements. Traditional societal values had little effect on their lives because of the particular community they lived in. Another group marriage, comprised of four adults and four children, broke down largely because the four adults were blue collar, lower-middle-class people trying to live in a suburban and highly conservative community. The societal and family pressures were too great for this lifestyle to survive in its surroundings, yet none of the adults were willing to move out of that type of environment. Part of the

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therapeutic task was to clarify the societal impact on their lifestyle choice.

In obtaining professional help for a lifestyle choice, a client needs to find a therapist who is aware, comfortable with, and informed about the various options. There are training and educational opportunities available. The American Association of Sex Educators, Counselors, and Therapists (AASECT) requires professionals seeking certification to participate in a sexual attitude reassessment (SAR) where attitudes and values are confronted and discussed through the viewing of explicit films regarding sexuality and sexual lifestyles. This is an important process for all who are working with persons and their sexual lifestyles. SARs are now available throughout the country through professional organizations, some graduate schools, and continuing education programs (see AASECT in References). The various professional organizations in the field of human sexuality also provide workshops and professional opportunities to learn more about the various lifestyle options that people are choosing (see addresses in References). Many universities and graduate schools are also introducing courses on alternative lifestyles.

With the majority of Americans living at one point or another in an alternative sexual lifestyle, it is becoming increasingly important for the marital therapist to be informed, trained, and comfortable regarding lifestyle options.

"A friend is someone who knows all about you and still loves you" **Kelly Digby**

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HYGIENIC AND SAFETY STANDARDS

FOR THE PRACTICE OF ELECTROLOGY

Preface

The American Electrology Association's Hygienic and Safety Standards for the Practice of Electrology are interim standards, subject to revision. Voluntary adherence to these standards should assist electrologists and electrology instructors to develop a practical aseptic conscience and an awareness for sanitary precautions. Because new studies and theoretical rationale are constantly revealing pertinent information relevant to these standards, revisions and/or additions will be made as necessary.

The standards were chosen primarily for their acknowledged importance to infection control. Some standards are based on well documented epidemiologic studies; others are based on a reasonable theoretical rationale, since for many of these practices little or no published scientific evidence is available to permit evaluation of their effect on the incidence of infection.

The standards have been developed for use by electrologists and electrology instructors and emphasize the need (1) to consider all patients as potentially infected with bloodborne pathogens and (2) to adhere to infection-control precautions for minimizing the risk of exposure to blood or body fluids visibly contaminated with blood of all patients, to reduce the risk of transmission of infection and disease from patient to patient, practitioner to patient, and patient to practitioner. Blood and body fluid precautions are consistent with the "Universal Precautions" developed by the Centers for Disease Control.

Although the standards have no force of law, state boards regulating the practice of electrology are encouraged to consider adoption of them, and professional associations should promote members' voluntary compliance with the standards. Both state boards and professional associations are encouraged to present continuing education seminars, lectures, and literature reviews to assist prac-

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titioners and instructors in developing a knowledge base on infection control and patient safety, thereby protecting the public and the practitioner.

Purpose

The American Electrology Association's Hygienic and Safety Standards will assist and encourage the practitioner to:

1. Develop a knowledge base of infection control and patient/client safety.
2. Develop a practical aseptic conscience.
3. Maintain a state of cleanliness to minimize the transmission of microorganisms.
4. Demonstrate expert skills in cleaning and caring for disposable and reusable instruments.
5. Make sound professional judgments and decisions.
6. Provide high quality patient/client care.
7. Participate in continuing education.

OVERVIEW OF ELECTROLOGY PROCEDURES

Needles/probes used in routine procedures penetrate the skin and become contaminated with blood, serum, or other material on the skin or in hair follicles.

Other procedures such as probing for and removing ingrown hairs result in blood contamination of instruments and can result in contamination of related surfaces, as well as the electrologist's fingers and hands.

CONCLUSIONS

Electrology should be viewed as parenteral when developing strategies for patient/client safety.

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Needles/probes and forceps/tweezers should be cleaned and then sterilized before use, and between patients/clients, by a method that is capable of being standardized and routinely monitored for effectiveness, i.e. dry heat or steam under pressure.

A fresh pair of nonsterile disposable examination gloves should be worn by the electrologist during the treatment procedure of each patient/client.

A proper hygienic environment should be maintained and infection control procedures followed to minimize the risk of transmission of infectious diseases.

SECTION 1:

STANDARDS FOR HAND WASHING AND USE OF GLOVES

1.Handwashing.

A. A sink with hot and cold running water should be located in each treatment room.

B. Hands should be washed:
   (1) Before and after treatment of each patient/ client.
   (2) Before putting on gloves and immediately after gloves are removed.

C. Handwashing should include use of plain soaps:
   (1) Bar soaps should be kept on a rack to allow water to drain.
   (2) Liquid soap containers should be disposable; or
   (3) Reusable liquid soap containers should be cleaned and refilled with fresh soap at least once a month.

D. Handwashing technique should include:
   (1) Use of plain soap and water;
   (2) A vigorous rubbing together of all surfaces of lathered hands, especially between fingers and fingernail areas, for at least 10 seconds;

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(3) A thorough rinsing under a stream of water; and

(4) Hands dried thoroughly with disposable paper towel, and then faucets turned off with the paper towel.

2.Use of Gloves.

A. A fresh pair of nonsterile disposable examination gloves should be worn during the treatment of each patient/client.

B. Hands should be washed in accordance with the Handwashing Standards before putting on gloves and immediately after gloves are removed.

C. Low powdered gloves should be worn and/or excess exterior powder should be removed with a clean disposable paper towel moistened with tap water and dried gently with a clean disposable paper towel to prevent powder from contacting patients'/clients' skin surface during treatment.

D. When a treatment session is interrupted:

(1) A fresh disposable plastic overglove should be put on over the gloved hand/hands; or

(2) A protective covering should be used over the gloved hand/hands; or

(3) Gloves should be removed and discarded.

E. When gloves are removed during a treatment session, hands should be washed and a fresh pair of gloves used.

F. Gloves should be worn during the procedures of mechanical pre-cleaning, cleaning, rinsing, and drying of needles/probes and forceps/tweezers.

G. Torn or perforated gloves should be removed immediately and hands should be washed after gloves are removed.

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SECTION 2:

STANDARDS FOR CLEANING AND STERILIZATION OF INSTRUMENTS/OBJECTS AND OTHER SAFETY PRECAUTIONS

1.Cleaning and Sterilization of Instruments/Objects and Other Safety Precautions.

A. Needles/probes and forceps/tweezers should be cleaned and then sterilized before use and between each patient/client.

(1) Gloves should be worn during the mechanical pre-cleaning, cleaning, rinsing, and drying of instruments and caution taken to avoid needle/ forcep stick injuries.

B. All trays/containers holding contaminated needles/ probes and forceps/tweezers and tray/container lids should be cleaned and sterilized daily or whenever overtly contaminated.

C. Pick-up hemostat/forcep/tweezer and holding cylinder should be cleaned and sterilized daily or whenever overtly contaminated.

D. Unused instruments in trays/containers that have been opened should be reprocessed after a 24-hour period.

E. Instruments contaminated before use, e.g. dropping or touching a soiled surface, should be reprocessed before use.

F. Needles/probes should be:

(1) Mechanically pre-cleaned using a clean cottonball or swab moistened with a solution of low-residue detergent and cool water; and

(2) Accumulated in a holding container by submersion in a solution of low-residue detergent and cool water; and

(3) Thoroughly rinsed with warm water and drained; and

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(4) Cleaned by soaking in a protein dissolving detergent-enzyme cleaner used according to manufacturer's instructions; or

(5) Cleaned in an ultrasonic cleaning unit used according to manufacturer's instructions; and

(6) Rinsed and dried.

G. Needles/probes and forceps/tweezers should be packaged individually or in small multiples; or unpackaged and handled using aseptic technique.

H. Aseptic technique should be followed when handling sterilized instruments/objects.

I. Instruments/objects should be sterilized by the following methods:

(1) Dry Heat.

(a) The following time-temperature relationships are recommended, i.e., including, but not limited to:

(i) 340° F (170° C) - 1 hour

(ii) 320°F (160°C)- 2 hours

(b) The above temperatures relate to the time of exposure after attainment of the specific temperature and do not include a heat-up lag time; or

(2) Moist heat (steam under pressure) -- autoclave.

(a) The following time-temperature relationships are recommended, or other time-temperature relationships recommended by the manufacturer of the instrument:

(i) 15 minutes at 121° C (250° F); 15 psi (pounds per square inch) for unpackaged instruments/objects.

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(ii) 30 minutes at 121° C (250° F); 15 psi (pounds per square inch) for packaged instruments/objects.

(b) The above exposure time relates only to the time the material is at temperature and does not include a penetration of heat-up lag time.

J. Dry heat ovens and autoclaves (steam under pressure) should be registered with the Food and Drug Administration (FDA) and should be cleaned, used, and maintained according to the manufacturer's instructions.

K. Sterilizers should have visible physical indicators, i.e. thermometers, timers.

L. Chemical (i.e. color change) indicators should be used on/in each package/container to assure that each package/container has been processed through the sterilization cycle.

M. Biological indicators should be used once a month according to manufacturer's instructions to assure the sterilizer is functioning properly.

N. To prevent accidental needlestick injuries, disposable or damaged needles/probes should not be recapped, bent, or otherwise manipulated by hand prior to disposal. Disposable or damaged needles/probes should be placed in a sturdy puncture-resistant container. Disposal of the container should be as follows: the contents should be disinfected with a freshly prepared 1:10 dilution of household bleach and water (1 part bleach and 9 parts water); allowed to sit for 30 minutes; solution poured off; and the container securely sealed and disposed into the regular trash disposal, unless otherwise specified by state and local health regulations.

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SECTION 3:
STANDARDS FOR ENVIRONMENTAL CONTROL AND HOUSEKEEPING

1.Environmental Control.

A. Offices and treatment rooms should be clean, well-lighted, and provide good ventilation.

B. A sink with hot and cold running water should be located in each treatment room.

C. Toilet facilities should be available.

D. Fresh disposable paper drapes should be used on the treatment table/chair for each patient/client. Paper drapes should be stored in a closed cabinet.

E. Soiled disposable items should be discarded into a container lined with a plastic bag, securely fastened and disposed daily into the regular trash disposal, unless otherwise specified by state and local health regulations.

F. Removable tip of epilator needle/probe holder should be removed after each treatment and cleaned with soap/detergent and water, rinsed, dried and disinfected by submersion in 70% isopropyl alcohol for at least 10 minutes. The covered container used to hold the alcohol should be emptied at least weekly or whenever visibly contaminated,then cleaned, dried, and refilled with fresh alcohol.

G. Non-removable tip of epilator needle/probe holder should be wiped with a detergent-germicide after each treatment.

H. Epilator needle/probe holder cord in direct contact with the patient/client and/or practitioner should be wiped with a detergent-germicide after each treatment.

I. Magnifier lamp/treatment lamp should be wiped with a detergent-germicide after each treatment.

J. After each use, patient/client eyeshields should be cleaned using a brush and soap/detergent and water then rinsed and dried.

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2.Housekeeping.

A. A hospital-grade disinfectant-detergent registered by the Environmental Protection Agency (EPA) should be used for cleaning environmental surfaces.

B .Bloodspills on environmental surfaces should be cleaned according to the following procedure: gloves should be worn; paper towels used to blot up the visible material; paper towels then discarded into a plastic bag, securely fastened and disposed into the regular trash disposal, unless otherwise specified by state and local health regulations; area wiped down with paper towels and an EPA registered "tuberculocidal" disinfectant-detergent or a freshly prepared 1:100 dilution of household bleach and water (1/4 cup bleach and 1 gallon water); area allowed to air dry; and paper towels and gloves discarded into a plastic bag, securely fastened and disposed into the regular trash disposal, unless otherwise specified by state and local health regulations.

SECTION 4:
STANDARDS FOR PATIENT CONSIDERATIONS

1.Patient Considerations.

A. Blood and body fluid precautions should be consistently used for all patients/clients.

B. A complete past and current health history/assessment should be obtained from each patient/client prior to treatment. The history/assessment should be updated and evaluated on a current basis.

C. The skin site should be evaluated prior to each treatment.

D. Patient/client should be referred to an appropriate physician when evaluation of skin surfaces and/or health history/assessment indicates.

2. Pre and Post-Treatment of Skin Site.

A. Before treatment, the skin site should be cleaned of visible soil using soap and water or a germicidal skin preparation,

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then wiped with an acceptable antiseptic product, i.e. 70% isopropyl alcohol, iodophor, or other acceptable antiseptic product.

B. After treatment, the skin site should be wiped with an acceptable antiseptic product, i.e. hydrogen peroxide, witch hazel, or other acceptable antiseptic product.

C. Application of ice in a fresh disposable plastic bag and/or healing cream/lotion/ointment may be applied to the treated skin site at the discretion of the practitioner. Creams/lotions/ointments should be kept in clean covered containers and handled in a sanitary manner.

D. Patient/client should be instructed on the appropriate post-treatment care to promote healing of the treated skin site.

For the complete Standards, write to:

AMERICAN ELECTROLOGY ASSOCIATION
106 Oak Ridge Road
Trumbull, Connecticut 06611
(Cost: $5.00)

OF MYTHS AND BREAKTHROUGHS

by Phyllis Austin

Introduction

This article appeared in the Maine Times, 1989, and your editor felt it important that the readership know about Joe Campbell and his important work on mythology and its interpretation for all humanity, regardless of cultural roots.

Some of his ideas of the myths of male/masculinity and female/femininity have much relevance for CG behaviors. We would like to hear from the readership if you would be interested in other articles about this man and his works. (Ed.)

* * * * *

For years, and through several moves, I carted around Joseph Campbell's books -- The Hero with a Thousand Faces, The Masks of God, Myths to Live By. I never read them. But every time I packed and unpacked them, I reminded myself that they were important, and I should read them. On a Sunday morning not long ago, I kept my destiny with Joe Campbell.

Sitting at home clipping stacks of newspapers, I switched on public television. The program was a replay of the Bill Moyers' nationally acclaimed "Joseph Campbell and The Power of Myth" -- a series that somehow had eluded me. Not having heard about it, I wasn't expectant.

But in a matter of minutes, I had put down my scissors, crawled up on the couch, and was completely absorbed in the conversation. Mythology, Campbell said, is the literature of the universe -- stories of our search through the ages for truth, for meaning, for significance. It comes from the heart, "even as the mind may wonder why people believe these things."

Campbell found a commonality of themes in the tales that diverse cultures concocted to explain the mysterious, wondrous, and

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frightening world around them. Ultimately, mythology leads us to the meaning of the experience of being alive:

"Anyone who has had an experience of mystery knows that there is a dimension of the universe that is not that which is available to his senses," Campbell said. "There is a pertinent saying in one of the Upanishads: 'When before the beauty of a sunset or of a mountain you pause and exclaim, 'Ah,' you are participating in divinity.' Such a moment of participation involves a realization of the wonder and sheer beauty of existence."

Campbell darted in and out of the realms of East-West mythology, psychology, anthropology, religion, and philosophy. His knowledge and deep insight into the sweep of our panoramic past was awesome. I, the listener, couldn't name many more than a dozen Greek and Egyptian gods and goddesses. Still, I understood what Campbell was saying. One of his gifts was being able to translate and distill the whole world's mythology into language and concepts that anyone could grasp.

After the program, I knew that I suddenly had an essential piece of life's puzzle that had been missing. It was jolting. (Believe me, I don't usually have pivotal experiences watching TV.)

Campbell's message gave me a sense of connection on a universal scale, revitalized and deepened my sense of wonder, and put my fears in much greater perspective. It not only affirmed my personal work with Buddhist teachings but dovetailed them in fundamental ways.

How could I have missed this link for so long? I was simply amazed.

And I could recite Campbell's own personal history almost like a member of my family. He felt like an older wise teacher and clearly was a man of great elegance and humanity.

MYTHS AND BREAKTHROUGHS

Campbell began following his "bliss" while still a boy. He became fascinated by American Indian totems and masks and from then on was on the path of something heroic. His scholarly quests led him to Dartmouth, Columbia, and the universities of Paris and Munich. He "retired" for four years at the age of 30 to immerse himself in the classics. Whether it was the legendary figures of the Hindu or the works of Jung or Picasso, Campbell was always looking for the overarching patterns of human perceptions. Perceptions that emerge in the myths that bonded tribes and cultures, that influence their art and music and the rituals they performed.

Campbell's works were so rich and on such a large scale that I couldn't absorb them quickly. It will take much study, reflection, and continuing experiences of life. Two of his ideas, however, seem to float regularly in and out of my conscious mind -- the "breakthrough" and the heroic journey.

I was sitting in a snowfield on the side of Mt. Webster in the White Mountains several weeks ago when the "breakthrough" image materialized. We were climbing Central Couloir, whose snow and ice fields were open wide until the very top. About halfway up, we turned around to enjoy the views of Crawford Notch. With Campbell's themes bubbling in my head, I was struck differently by the bold expanse of mountains and space. The visual impact was out of the ordinary, and I wanted to leap into the sky.

Campbell often used the fingers of one hand to push through those of the other hand -- the symbolic breakthrough that he said myths evoke to allow us a transcendent experience. And there it was for me. Such wonder, Campbell said, is the "ultimate" contact with being alive. On another day climbing Mt. Washington, I pondered Campbell's hero -- "someone who has given his or her life to something bigger than oneself."

Mythology is replete with heroes seeking adventure, suffering or dying while performing a courageous act or engaging in a spiritual

MYTHS AND BREAKTHROUGHS

deed -- typically returning with an important message or sustenance. I felt heartened by Campbell's belief that every one of us has heroic potential. For those who feel a call buy remain in a place because they view it as safe and secure, "then life dries up," he said.

"If you realize what the real problem is -- losing yourself, giving yourself to some higher end, or to another [person] -- you realize that this itself is the ultimate trial." The most glorious deeds and inner struggles, he said, result in spiritual rebirth and the way to living to our potentiality.

Joe Campbell died in October 1987. I miss his presence in this earthly realm, as I'm sure many do who never met him or had the pleasure of attending one of his classes or lectures. A friend of his, Huston Smith, said it well in a eulogy to Campbell: "It was his contagious verve and exuberance, the height of his bound on life's trampoline, I think, that endeared him to us most."

Book Review

Transvestites and Transsexuals

Richard F. Docter

(Reviewed by N. S. Ledins, Ph.D.)

Two passing notes must, perforce, be stated quickly: (a) Richard Docter, Ph.D., having had access to the outstanding Bullough Library of Sexuality at Cal. State Northridge (CA), has produced a tome worthy of review and comment; (b) Dr. Docter's sub-title "Toward a Theory of Cross-Gender Behavior" is most important to remember as the book is both read, digested and evaluated. It is in the sub-title or secondary title that Docter gives us the massive nature of the undertaking.

At the outset, it is imperative that two critical aspects of the Docter book be prominently noted: (a) time and again, Docter warns the reader to be cautious in accepting data and statements which are less than "conclusive" or "decisive"; (b) the author takes great patience and time (in paging terms!) to present a serious paradigm configuration concerning cross-dressing and, by extension, genderal transiting behavior.

To the first point: Docter is very clear in pointing out that, although he will occasionally use the DSM-III-R (the "bible" of the mental health practitioner), "we will remind our readers that we see both good and harm in using this medical model terminology" (viii). Sound advice since, as many of us have stated in the past, the so-called definitive ruling on the phenomenon and etiology of cross-dressing and gender dysphoria have not yet been found or described. Since each of us has "a slit view of reality," it is refreshing to read the following caveat: "We do not assume that either transvestism or transsexualism ought to be conceptualized as disorders." Score one for Doctor Docter!

Concerning the second point, Docter is clear in pointing out that, "although we will discuss transsexualism, it is a minor theme" (vi). In an interesting way, his ultimate points do very much revolve around a premise of "secondary transsexualism" which is innovative

Book Review

but, unfortunately, simply that: a conclusion without a great amount of evidence. The point does, however, capture a segment of the genderal issue not heretofore viewed either in great depth or from the same "slit view." Ultimately, Docter's point will be that, "much if not most transsexualism is secondary and that such transsexualism follows an extensive career in either a transvestite or homosexual form" (viii). It is this position which has understandably caused much furor and angst among many in the so-called paraculture. Whether most transsexualism is the product of a transvestic developmental struggle will be an interesting point to pursue in the years to come.

The author, to continue, must be credited with facing down some of the proclaimed "giants" of the field and -- gently to be sure -- disagreeing with some of the gratuitous claims made by many. To note a few examples: Stoller ["his perennial but poorly supported theory of the distant father" (p. 89)], the Johns Hopkins "research" of a decade ago ["leaves much to be desired" (p. 69)], Gagnon ["sexual script definition is poor" (p. 95)], Gosselin and Wilson [". . . use of the Eyseneck Personality questionnaire leaves the facts far from clear" (p. 54)], and so on. Page after page is spattered with small, sideslip notes such as, "nothing more than an interesting hypothesis," "the final word is still out," "there is a weakness of factual information," "facts to support this scenario have not, thus far, been well established," ". . . the evidence is far from clear," "little detailed knowledge exists," ". . . studies are far from decisive," "promising but in no sense conclusive," ". . . existing base of follow-up research . . . is so incomplete and methodologically flawed. . . ."

Perhaps, in a point well taken, Docter is quite correct in our estimation in noting that "gender identity is a hypothetical construct and . . . no objective measurement scheme has yet been invented" (p. 74).

Docter's real theme, after saluting the theorists of the past (and present) is to patiently build the foundation of his own theory. He reminds us that "it is fair to point out that neither this study (Bullough) nor any other has, as yet, identified the critical, causal factors in

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transvestism, transsexualism, and homosexuality" (p. 60). The last half of the book then sets out to share his view through a basic, cognitive psychological theory which rests on the foundation that, in most cases of transsexualism (or gender reassignment) it occurs only after extensive fetishistic cross-dressing has been learned and practiced (viii). Thus, on page 89 he notes that "there is a growing acceptance of the view that most transsexuals do not meet the criteria for primary transsexualism . . . although hard data is lacking." There is a sense that his primary thesis is that one's search for identity is based on an Allportian- Rogerian-Sarbinian-et al. theme of "self-esteem" which, if not found in regular ways, will be searched for until found -- even if it means a massive upheaval in one's life. He is quite clear, however, to point out on page 133 that "as yet, the final word is out." It is clear, however, that he leans strongly toward the belief that the basic learning processes offer the strongest explanation for these behaviors.

Docter points out that there are four explanatory constructs which constitute the unifying theme of his book: sexual arousal, pleasure, the sexual script, and cross-gender identity (p. 199). He rejects the biological script of Prince, the Stoller perspective, and even the Benjamin-Hoenig "biologism forces."

On a somewhat lighthearted but pointed note: The very last printed entry in the book appears in the Index of words where we read "transvestism and anxiety reduction." The book has set out to reduce anxiety over this strange phenomenon. As with most books on this subject it does not. However, as Docter points out in his preface, he is proposing a theory of transvestism and secondary transsexualism. Like many of its predecessor theories, it still remains just that. But, as the author so aptly says, "I agree with other gender researchers who have concluded that the causes of transvestism and transsexualism remain largely unknown" (p. v). But, as he quickly points out, it does not mean we cannot try to propose a possible theory. Thus, his work deserves a sound B+ for attempting the so-far impossible dream.

Book Review

BODYSHOCK:

The Truth About Changing Sex

Liz Hodgkinson

Reviewed by Rupert Raj

A tall order to fill, within the pages of such an introductory -- though compact -- little book, the author does succeed, to a limited extent, to live up to the subtitle of her report on people who have "changed sex." A British freelance journalist by profession, Liz Hodgkinson tells the everyday man and woman about some of the "real" reasons why certain individuals have crossed the sex line (or are contemplating doing so). In spite of several inaccuracies and a couple of blatant omissions, the general facts, as they relate to transsexualism and sex reassignment, are presented to the reader in a clear, straightforward manner by means of an easygoing storytelling style. In fact, Hodgkinson weaves a good tale, catching the reader's attention -- and hopefully empathy -- with her lively narration of some of the more colorful examples of "sex-switched" celebrities in Britain and the United States.

She recounts a number of case histories gleaned from the Self Help Association for Transsexuals (SHAFT) in England, letting these members, for the most part, speak for themselves. (As a point of interest, the author dedicated her book to the Founder of SHAFT, Judy Cousins -- a "new woman" who used to be a male officer in the Indian Army and who is now, in her 70s, a grandmother and talented sculptor).

To her credit, Hodgkinson includes accounts of no less than seven English female-to-male transsexuals, two of whom have since passed away, Radclyffe Hall -- a well- to-do novelist who was tried by the Crown for her 1928 semi-autobiography of a female sexual "invert" -- in this case, a masculine woman who felt more like a man -- the book being banned in England shortly after its release, with Hall

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dying 15 years later from cancer, despite the dedicated nursing of her long-time lover, Lady Troubridge; and Dr. Laurence Michael Dillon -- a "blue- blooded" ship doctor who was the first female known to have had a penis surgically created in 1948 and who later went on to become a Buddhist monk, and eventually died of malnutrition in a Tibetan lamasery in 1962. (Hodgkinson has penned a biography of Dillon entitled Michael, nee Laura, also published by Columbus Books, in April 1989). Probably the most interesting modern-day F-M TS the writer tells us about is Mark Rees -- a middle-aged university graduate who sued the U.K. government (and lost) in a widely publicized human rights case in 1986, on the grounds that the British Crown was denying his rights to privacy and equality by not legally changing his sex designation on his birth records.

And, of course, there are accounts of eight modern- day male-to-female transsexuals living in Britain who have had the surgery, including a Canadian named Dora -- a computer consultant who considers herself a feminist. Two of the English "new ladies" are Rachael Webb -- a radical feminist community worker and left-wing Labour Councillor who was chastised by the press for getting her operation "on the rates," and who now works with lesbian and gay groups and campaigns for transsexual rights; and Stephanie Anne Lloyd -- a former successful businessman who recently founded a private gender clinic, an inn, several clothing shops, and a line of magazines and other products -- all for the transvestite and transsexual.

The book also includes sections dealing with the etiology, psychology, medical management (hormones and surgery) and legal aspects of transsexualism, as well as how the condition differs from both homosexuality and transvestism, and also how it affects others.

The reader can almost put up with the fact that this is not a well researched report (which is patently obvious by glancing at the sparse bibliography at the back of the book or by noting the existence of a

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minimum of statistical data) when its other merits are weighed in the balance. These include such considerations as sexual equality, social gender roles, androgyny, and relations between women and men in society.

In her chapter "Transsexualism and the Battle of the Sexes," the author discusses the controversial issues and concerns surrounding Janice Raymond's forceful argument that transsexuals are "constructed" males and females who "contribute to the continuing gap between the sexes by reinforcing sex stereotypes in the gender-identity clinics and then living them out after they have changed over" (p. 170). Raymond, a feminist anthropologist who wrote The Transsexual Empire (1979), goes on to say the transsexual experience makes us aware how far apart the sexes are, how much we judge people on their physical appearance, and that we judge people as men or women first, and as human beings second. It is clear that Raymond is not sympathetic to the transsexual condition. She hopes that "soon transsexuals may be able to accept themselves in their original bodyshape and consciously learn to become whole people while remaining in their original biological gender" (p. 181).

Hodgkinson, in spite of her partial support of Raymond's thesis, concedes that the whole subject is very complicated. She disagrees with Raymond that all transsexuals are stereotypical, saying she has "never met one who . . . conforms to the 'standard' picture of a man or a woman . . .," and that "once transsexuals become postoperative, they always have to redefine and modify their relationships with others" (p. 176). Yet, she does concur with Raymond that it would be good if maleness and femaleness could meet in the same person without that person being "gay or butch, transvestite or dykey." Rachael Webb's influence is also apparent, as the author's summary statement shows:

Transsexuals can teach us much about the way in which men and women regard each other -- the true, innate differences between

Book Review

the sexes, and to what degree biology and hormones play a part -- but only by being prepared to come out and state that they are transsexuals. . . . [They] are the only people who are in a position to promote harmony between the sexes, from their direct experience. They don't particularly have to make any political statements, just set an example of how it is possible to live successfully as both a man and a woman in the same basic body. . . . [T]hey can demonstrate that what sex you are doesn't matter all that much -- it is the person inside the body that really counts" (pp. 182-3).

This reviewer feels that Bodyshock deserves a well earned place on the bookshelf, alongside such other non- medical works as Feinbloom's, Stuart's, Bolin's, Devor's (in progress), and yes, even Raymond's -- all feminist researchers who presented their findings from a social science perspective, with a special focus on the definitions of gender roles within our society.

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ABSTRACTS of a SYMPOSIUM on GENDER ISSUES for the 90s

Part I of an All-Day Program for Health Professionals presented at III Annual IFGE Convention April 8, 1989

organized by the
Human Outreach and Achievement Institute
Boston, Massachusetts

A NEW GLOSSARY FOR BETTER UNDERSTANDING

We have long held the view that terms, categories and definitions which do not clearly describe a particular behavior should be avoided. However, we also recognize the need to bridge the gap between outmoded and misused terminology which has been used by professional people and the general public. Therefore, in the interest of improved clarity and better communications and understanding, the following glossary of operational terms is presented.

Androgyne: A person who can comfortably express either alternative gender role in a variety of socially acceptable environments (includes bigenderist).

CD/TS/AN: People whose general behavior pattern **Community** includes gender-related issues, androgyne and crossdressing.

Crossdresser: A person who wears articles of clothing of the opposite gender (includes TV, Female/Male Impersonator, etc.).

New Women/Men: A person who now lives in the preferred alternative gender role, and who has completed the surgery needed to achieve anatomical congruence (includes people who have had reassignment surgery).

Transgenderist: A person who has decided to transit from one gender role to a preferred alternative gender role permanently (includes pre-op transsexual).

Transsexual: A person who desires anatomical congruence with the preferred, alternative gender role preference (includes persons wanting sex reassignment surgery).

INTRODUCTION

Gender Issues for the 90s

All-Day Program

For the past two decades we have been engaged in unraveling the mystery surrounding the concept of gender, as a social and cultural phenomenon, rather than just a "psychosexual disorder." We have learnt much about some of the social dynamics of gender shift, some of its determining factors, and some effective coping strategies in dealing with gender conflicted people.

This program will consist of two distinct parts:

A. Symposium

A panel of presenters on relevant gender issues for the 90s with other approaches toward understanding the complexities of gender (9:00 a.m. - Noon). This segment is open to all registered conference attendees.

B. Workshop

New and diverse strategies for counseling and doing therapy with gender conflicted clients. Several tested and useful "tools" will be presented. These can be used in connection with various coping strategies available to sex educators, counselors and therapists (1:30 - 4:00 p.m.). This segment is open to registered counselors, therapists and other helping professionals only. A limit of 20 to 25 people has been set.

The All-Day Institute on Gender Issues for the 90s is sponsored by the Human Outreach and Achievement Institute (HOAI). It is presented in conjunction with the International Foundation for Gender Education (IFGE) at its Annual Convention in San Francisco.

Gender Issues for the 90s

The Human Outreach and Achievement Institute

The Human Outreach and Achievement Institute is a "not for profit" corporation whose purposes and objectives are educational and personal growth oriented. In continuous operation for more than a decade, we have developed several clinical programs and workshops for helping professionals throughout the United States. These are presented to provide clinical tools and broaden the perspective of the health care professional working in the general area of human sexuality, and are specifically focussing on issues of gender role/ identity.

The Institute reaches out to the general public through invited speaking engagements to lay groups and selected video appearances on local and national talk shows (e.g., The Donahue Show). To the professional and academic community we have given many lectures, seminars and panel discussions at local and regional clinics, and university graduate programs in psychology and sociology. These have been presented at major academic and urban settings in the United States, including Boston, Chicago, New York, Washington, D.C., Miami, Phoenix, San Diego, Los Angeles and the Bay Area of San Francisco. Helping professionals from the fields of education, medicine, guidance and counseling, sex therapy, law and law enforcement, nursing and human services have attended one or more of our programs and workshops.

Presenters

The Social Dynamics of Gender Shift
by Ari Kane, M. Ed.

Past Life Imprinting
by Nancy Ledins, Ph. D.

Social Contact Groups for Crossdressers
by Naomi Owen, J. D.

Gender Issues for the 90s

What Do We Know About Gender Issues
by William R. Stayton, Ph. D.

A Transsexual's View of Masculinity
by Louis G. Sullivan, B. A.

The Social Dynamics of Gender Shift
by Ari Kane, M. Ed.

Gender shift is defined as a strong desire of a person to adopt an alternative gender life pattern to that in which she or he has been living for most of her/his life. We will examine the underlying bases for gender shift (G-S) and discuss several important determinants that influence an individual's decision to choose an alternative life pattern. An overview of the gender concept will also be presented.

Ari Kane is executive director of the Human Outreach and Achievement Institute and currently has a private counseling practice, specializing in gender issues, in Brookline, Massachusetts. He is a nationally recognized speaker on gender issues and counseling education and has appeared on several major radio and television talk shows. In addition, he gives seminars and workshops at many universities and mental health centers throughout the United States. Currently, he is pursuing a graduate program in Humanistic Sciences at the Saybrook Institute in San Francisco, California.

Past Life Imprinting:

A Case for Dysphoric Genderal Resolution
by Nancy S. Ledins, Ph.D.

A past-life regression research project (1979-82) gave preliminary indications that past lives can have some bearing on dysphoric feelings. Indications leaned toward resolution by way of alleviation, through an application of a past-life therapy approach. Specifically, the preliminary research gave some credence to the harsh differences in the past life recountings of 147 cases of transsexuals against a

Gender Issues for the 90s

control group of 39 generally euphoric persons. Using Netherton's premise that "underlying past life imprintings can play a important role in resolving and alleviating dysphorias" including genderal ones, this study was attempted to see if soul memory imprintings needed resolution before a gender euphoria could be achieved. Data will be presented and interpreted by Dr. Ledins.

Nancy Ledins is director of education for a national technical school system in California. She holds degrees in psychology, philosophy and theology. Her professional career path includes important work in chemical dependencies and recovery programs, suicide programs, counseling and therapy for the gender conflicted, electrology education and "out-of-body" research. She is the author of **Tippet and His Friends**, a book for teens and adults who have not lost the magic of their childhood.

Social Contact Groups for Crossdressers in USA:

Present and Future
by Naomi Owen, J.D.

The forerunners of today's CD social contact groups and clubs first came into existence about 25 years ago. The founding members of these clubs, fearing ridicule and rejection, operated them in total, almost paranoid secrecy. Several individual members of the CD community went "public" in the late 60s and 70s to call attention to the existence of these groups. Today social contact groups and clubs can be found in every major population center (city) in the United States.

Generally, the helping professionals (counselors, therapists, psychiatrists, psychologists, social workers and medical personnel) have little understanding of this extremely complex behavior. There are few reliable sources of information. Those professionals who have worked with clients see only the tip of the iceberg when they work with clients in a crisis or those who seek counseling.

Gender Issues for the 90s

Over the past decade there has been growing acceptance by some helping professionals that CD social contact clubs can and do generate a positive impact on their members and their significant others. Heightened self-esteem, respect and pride can be achieved when a CD elects to affiliate with a social contact group having a program of growth. Fear, guilt and self-doubt can be greatly reduced. The CD clubs have made great strides to eliminate some misinformation and myth surrounding crossdressing.

What are the dynamics of a good CD social contact club? How can the helping professional tap the resources that such clubs provide? What kinds of programs can a CD club provide for its members? What kinds of outreaching are possible through these clubs? How can these groups help in working with significant others? How can and do some CD social contact clubs present a positive public image without compromising individual self-image and self-respect? These are some of the main areas that will be covered in this presentation.

Naomi Owen is a prominent attorney from the Midwest. He has served as an officer and director of many legal, charitable and community organizations. As an active CD, he has appeared on many radio and television talk shows all over the United States. In addition to serving as the president of a large and very successful CD social contact group in the Midwest, he is also a member of the Outreach Institute board of directors and the IFGE board of directors. "She" has earned a reputation of being an articulate, knowledgeable and entertaining speaker on this subject.

What Do We Know About Gender Issues
by William R. Stayton, Ph.D.

One of the major problems for both professional and lay persons is confusing issues around gender. Until we can understand the different developmental issues around gender and separate them out from each other, we cannot begin to explain or educate about them.

Gender Issues for the 90s

This presentation will attempt to identify the issues and separate them so that more understanding can take place in explaining them. The developmental issues that will be discussed are identity, role, orientation, and lifestyle. These are the gender issues for the 90s.

William Stayton is the director of a full-service mental health center, specializing in Human Sexuality Issues. He is a sex therapist and educator and has presented numerous professional papers at annual meetings of the Society for Scientific Study of Sex (SSSS) and American Association of Sex Educators, Counselors and Therapists.

A Transsexual's View of Masculinity
by Louis G. Sullivan, B.A.

Society's concept of "masculinity" has been and continues to be based on media-entrenched stereotypes that stem from the heterosexual struggle between the "liberated" female and the resulting sex-role confused male. While women have defined and fought against centuries old, sexually based oppression, men have not fully understood how they are "strangled" by the sexism of masculinity.

Inherent in this dichotomy between female liberation and male sexual ambiguity is the fear of homosexuality in the latter. This homophobia is found in many aspects of American society, including some clinics which focus on gender-related issues and conflicts.

Data will be presented to support the above statements and to outline avenues to change the prevailing "heterosexist-defined" masculinity.

Louis G. Sullivan is a post-operated female-to-male transsexual who lives in San Francisco. He is a regular speaker on crossgender issues at the Institute for Advanced Studies in Human Sexuality and has written extensively about female-to-male social contact groups. He is involved and committed to educating health care professionals about the process, dynamics and attitudes of female-to-male gender shift.

AN INVITATION TO JOIN OPERNs

There has long been a need for sensitive and responsive INTAKE, EVALUATION and COUNSELING SERVICE, nationwide,for people of all ages needing help in resolving personal gender problems. These would include crossdressers, gender dysphorics, transsexuals and androgynes. In answer to the need, the Human Outreach and Achievement Institute has organized the first network of its kind, Professional Evaluation and Referral Network **(OPERN).** Annual membership is $25. Write to The Institute for an application.

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