

Recovering From Paraphilia: An Adolescent's Journey from Despair to Hope

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As the background information of the new referral to Calgary's Phoenix Program for adolescent sexual offenders was being revealed at the staff intake meeting, looks of incredulity, shock, and even some disgust began to spread across the faces of these time-tested professionals. These were staff persons who had seen and worked with adolescent young people who had involved themselves in socially unacceptable activities ranging from the naive and inappropriate to the heinous and vile. It was, therefore, somewhat surprising to see their initial reaction to the background information about Robert¹, a 15-year-old boy being referred from Québec.

The Program Director was reading from a request for assessment and treatment that had been received from a Montréal children's aid program. The request outlined how Robert had been apprehended by Québec's Social Services at the age of 13 as a result of disclosure by his younger sister and his sister's friend that he had had sexual intercourse with both of them. At the time, Robert's sister and her friend were eight years. The referring psychologist depicted how Robert had been able to superficially comply with residential treatment rules in the Québec program, but seemed to have difficulty grasping the deeper concepts of his personal social responsibility as it related to the sanctity of another person's individuality. He was described as "taking minimal responsibility for offending his sister," "demonstrating no remorse," and as "mostly concerned with the consequences to himself." However, it was not these factors that seemed to alarm our staff, but rather the fact that the referral letter also confessed that Robert had disclosed having interest and arousal to reference to soiled diapers. Additional information revealed that Robert enjoyed anal insertion of objects, wearing diapers, soiling diapers, and sleeping in soiled diapers since he liked the feel of the feces against his skin. Finally, it was reported that Robert enjoyed fantasies of an older woman diapering him and caring for him.

The background information went on to indicate that since the disclosure of Robert's interest in diapers, he had become increasingly less able or less willing to "contain and control his sexuality." A chronicle of escalating behaviours on Robert's part and symmetrically escalating behaviours by the treatment program staff was sketched. For instance, Robert had begun going to public washrooms and stealing soiled diapers to bring back to the residential treatment program so he could masturbate with them. He also went to a nearby children's hospital to steal diapers, either clean or dirty. Initially, he used them in private; eventually, however, he began to wear them in residence during the day and to change them in public washrooms. If Robert was unable to get a diaper, he took to using white garbage bags and taping them to his body or using towels. He also continued to have periodic episodes of inserting objects in his rectum. Most recently, Robert had taken to running from the program to search the neighbourhood for diapers in people's garbage and had even got to the point of trying to steal them off children themselves!

¹ relevant identifying data have been changed.

In various assessments done in Québec by professionals in psychology, psychiatry and forensics, it was discovered that Robert showed a “paedophilic profile” on phallometric assessment. This further alarmed staff at his treatment centre despite Robert’s disclosure that he had no interest in genitally (sexually) assaulting the infants, but rather found arousal to the imagery of the diapers these children were wearing. As staff’s responses to Robert’s inappropriateness symmetrically escalated through increasing behavioural restrictions, use of antisexual medication, increased numbers of assessments, and referred consultations, Robert’s behavior continued to further escalate into breaking into day cares, asking for pacifiers and bottles, and not cooperating with program staff in treatment regimens. Eventually events escalated to the extent that Robert was removed from the treatment centre to which he had originally been admitted and was, in fact, given a group home with him as the sole resident and receiving 24-hour supervision. Although this permitted less milieu upset for the other residents of the initial treatment program, it did little to alter Robert’s preoccupation with diapers, bottles, and pacifiers. The referring letter wound up by saying that Robert had little hope for himself in ever being normal. Although occasionally he had indicated he hoped to have a normal life, Robert usually stated he instead looked forward to a time when he would have adult independence so that he could have as many diapers, bottles, and pacifiers as would want.

It seemed that the Phoenix Program staff were viscerally responding to three main elements of the case report that the Program Director was disclosing. First, the unusualness or bizarreness of Robert’s paraphilic² involvement with diapers³ was one factor. Second, the awareness that this fetishistic paraphilic behaviour involved feces⁴ for arousal no doubt also disturbed the staff. Thirdly, however, was the more instinctive negative response to fact that Robert’s actions increasingly involved interfering with children themselves.

Despite these gut responses, the Phoenix Program agreed to take Robert on a 30-day assessment trial to see if the milieux and treatment regimens could be helpful to him.

The staff asked me, as a Program Psychiatric Consultant, to meet with Robert. On my first meeting with him, he showed himself to be an appropriate, polite, and conscientious participant in our discussion. He appeared about his stated age and showed good physical growth. He was obviously postpubertal in the fact that he had developed a mustache and other obvious secondary sexual characteristics. Robert told me his current family consisted on a natural sister, Sheena, who at the time of our assessment was age 11. Both he and his sister were from a 15-year marriage between mother, Jane, age 39, and his father, Paul. These parents had now been separated for 11 years and his father lived in Philadelphia. Jane was then married to George, 38, for five years. They have now been separated for two years. George had brought to the union

²In describing the class of activities involving sexual arousal outside of usual expectations, I use the more modern term paraphilia (beside usual sexual loving) rather than deviancy or perversion (See Money, 1987)

³ termed by John Money “diaperism or infantilism” as a form of haptic or touch paraphilia.

⁴ a variant of coprophilia.

two older children, Alex, now age 19, and Rebecca, 17. Both of the older children were not in the home in which Robert had been growing up. Robert described himself as having a girlfriend, Molly, age 14, whom he had known for some years.

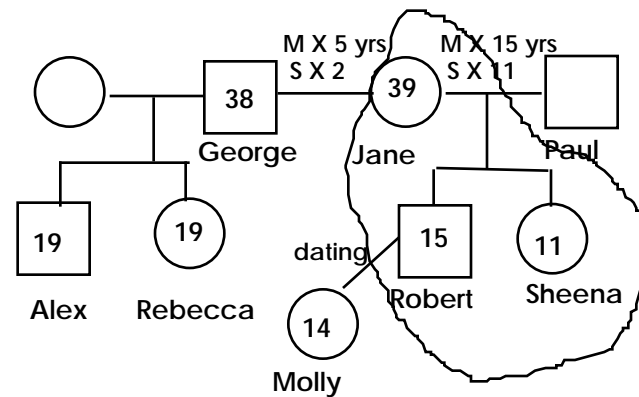


Figure 1 - Robert's Genogram

When Robert was admitted to the Phoenix Program for assessment, he was on two medications: Dexedrine 20 mg b.i.d., which he reportedly had been taking for four or five years, and Paxil 30 mg q.a.m., which he had been for two months. Robert stated the Dexedrine was for his hyperactivity and the Paxil was supposed to decrease his frequency of self-stimulation and preoccupation with the paraphilic behaviour; however, he said it did not affect either.

Robert was able to speak quite openly and confidently about his experiences in the Québec program and his anticipation of what would occur here in Phoenix. For instance, he recognized the inappropriateness of his sexual involvement with his sister and her friend, including his disclosure of attempted intercourse without success, fondling their genitals, and having the girls touch his penis.

In addition to reviewing “archeological” background information, a major focus of my initial discussion with Robert centered on his sexual development and self-stimulation habits. He reported that he had begun to self stimulate about age nine, began using diapers about the age of 10, learned to ejaculate about the age of 12, became curious about others bodies, particularly girls, about the age of 13, and found that the use of diapers dramatically increased following the discovery of his genital assaults. Robert also said he had taken to soiling the diapers to increase his erotic arousal. The usual scenario, he stated, went as follows: He would find a diaper (his preference was to have a new, larger fitting one), wear it until he soiled it, enjoy the erotic feeling of the warm feces against his skin, then find privacy to self-stimulate by pulling the diaper away from his body so he could have access to his genitals. He would imagine an older woman tending him, and cleaning him. Once he had self-stimulated to orgasm, he then would remove the diaper and clean himself of both semen and fecal matter. He denied using the fecal matter in the process of self-stimulation(e.g., as lubrication) and said he only used others dirty diapers when he could not have access to clean diapers in which he could personally soil. He went on to say that over the last couple of months he had

increased his use of diapers “in his head” as opposed to actual diapers, simply because they had been harder to come by as he was “incarcerated” in his own group home.

When I examined Robert’s insight into this paraphilic behavior involving diapers, Robert showed himself to be quite concrete with limited insight into its potential for disturbances of later interpersonal life. He was able through questioning, however, to see a connection between increased personal isolation and the decreased likelihood of effectively meaningful relationships, particularly with women, if he continued to privilege the diapers over people. When I asked what proportion of himself would want to emerge and “grow beyond” the diapers, he said about 50%, with the other 50% valuing the diapers, particularly once he was adult enough to own them on his own without interference by others. I then asked about his understanding of his involvement with the diapers. Robert stated they made him feel safe, secure, and nurtured, and that he often fantasized being changed in diapers by a nurturing female hand.

Robert revealed that he and his mother had developed an extremely close bond through the trials and tribulations of their life together. For instance, she continued to shower with him until the age of 10 and showed significant concern in him being outside the family, despite his unusual behaviours and inappropriate involvement with her younger daughter. However, both Robert and his accompanying documentation also spoke of Robert’s mother as being genuinely loving and caring.

It was now time to generate a potentially more helpful treatment plan for Robert. Although this, in itself, was not terribly difficult, the proof of the plan would be in whether the Program staff could be effectively invited into using the treatment plan rather than falling “prey” to culturally inculcated biases similarly to the previous program staff. The plan would need to be carried out in such a way that Robert would come to experience his life as emerging with treatment to be of greater value than the drift of his life involved with the paraphilia and symmetrically escalating conduct disorder. This would require a good dose of staff “complementarity.”

Concerning the specific treatment plan, I made the assumption that the elaboration of Robert’s paraphilic behaviours were occurring more in an effort to escape restraints placed on his experience by social and family settings rather than by any inherent “character defect.” As such, the treatment strategy that I suggested was as follows:

- a. Most important, an engagement into a voluntary and valued psychotherapeutic relationship - in this case a staff psychotherapist;
- b. Placement in a safe and nurturing residential facility with high tolerance of both group and individual idiosyncratic behaviours - the milieu of the Phoenix Program;
- c. Minimizing the use of medications. If they were needed, however, then to focus on their use to help with compulsive and obsessive phenomenology rather than sexual behaviours;
- d. The creation of a specific sociosexual developmental program including:
 - i. providing sexual information, including knowledge and permission and place (i.e., his own room) for private and appropriate self-stimulation
 - ii. increasingly generating private exercise that would enable Robert to

differentiate thoughts and fantasies from his habit of actually enacting the fantasized actions.

- iii once this difference was effectively realized, both through cognition and potential behaviours, Robert could then be invited into increasingly using his ability to “internalize and elaborate” whatever thoughts allowed his body to work effectively while only engaged in appropriate private sexual behaviour such as self-stimulation;
- iv larger system intervention in providing Robert with opportunity to learn and experience more effective social skills on a peer and staff level, and;
- e. The recognition that any overall treatment program for Robert would only be successful depending primarily on the lived interpersonal context in which he found himself eventually immersed. If, for instance, he became simply a curiosity or a pariah in the Phoenix Program due to the oddity of his behavior, his placement would serve to be a worsening agent in terms of prognosis, such as what had happened at his residential treatment program in Québec. If, on the other hand, peers and staff could come to see his efforts, as meager as they initially might be, as evidence of his excellent progress, the social affirmation that he so obviously sought through both the fantasies and the infantilism would be better met in a direct and developmentally more mature lifestyle.

With these treatment guidelines, plus the existing structure and groups of the milieu of the Phoenix Program, during his 30-day assessment period, Robert chose to voluntarily commit to a placement at Phoenix.

Over the subsequent 10 months, Robert showed excellent progress, although as with all adolescents some slips and slides along the way. When he was returned to Montréal 10 months after his admission, he no longer involved himself with diapers, fecal soiling, anal insertion, or larger system socially inappropriate activity such as breaking and entering, theft, and escalating noncompliance with authority. This, of course, is a dramatic change and the reader will no doubt be interested in how it was brought about.

My theoretical and therefore clinically enacted focus has been in the tradition of writers such as Bernie Zilbergeld (1987) who wrote the trade book *Male Sexuality*, Michael Foucault in examining the cultural evolution of sexuality, Jeffrey Weeks (1986) with his experiential focus on sexuality, and, in particular, the focus used by gays and lesbians (Sanders 1992, 1993) in escaping cultural myths of penetration being sex and replacing it with sex as an emotional/erotic experience⁵. Such emerging clinical traditions, garnered from my clients lives, buttressed by the above readings, have led me to several fundamental premises that I now use in my therapy work (Sanders 1986, 1988a&b, 1989). These are:

⁵ ... gays are in the vanguard of that final divorce of sex from conventional notions of sin; the divorce of sin from mythology and religion. If we can carry this off— if we can take sex out of the realm of sin altogether and see it as something else to do with personal relationships and ethics, then we can finally get around to another phase of Christianity which is long overdue. That phase is the one which deals with the question of sin as violence; sin as cruelty; sin as murder, war and starvation.
Writer Anne Rice

- Sex is an experience, not a set of specific behaviours.
- Thoughts are not linearly predictive of actions.
- Violence is essentially experiential, not a set of defined behaviours.
- Cultural drift, its stories of meaning and traditions of blindness, tend to be internalized and personalized rather than externalized and given to the cultural collective.
- The larger system (e.g., the Program staff and other helping professionals) determines the outcome of a client's future as much or more than the clients themselves.

a. Sex as Experience

Through my clinical experience, I have come to see that sex cannot truly be defined behaviourally as so many researchers and pundits have tried. Although genital behaviour may, at times, be seen as sexual, at other times it may be anything but as evidenced by Robert's sister's experience of his assault of her. Experiences such as those reported by persons who have suffered genital assault and abuse have helped me to genuinely question the assumption that sex had to do with certain behaviours such as intercourse and replace this assumption with sex as a mutual experience.

From listening more carefully to my patients, I distilled a series of five felt shared experiences between two people that appeared minimally necessary before the activities the two engaged in could be considered by our culture as mutual sexuality. Although I have described these "Five Sexy Words" elsewhere (Sanders 1991a), they are so fundamental that they bear repeating.

I will often orient clients to these Sexy Words in a reflective manner. As with clients, I will ask you to close your eyes after reading this paragraph. I would like you to privately remember, without acting on the memory or saying anything aloud, one of the better sexual experiences in your life. If this is difficult to do, then imagine how it would be if it could be. Now, I know as you bring this memory to mind that you will remember who you were with, where you were, and what you were doing, but I am more interested in you remembering what made this experience so special - what sorts of feelings, thoughts, and interactions did you have? When this is clearly in mind, continue to read.

Your best sex (even if anonymous, or for only one occasion) probably included the following:

1. First, you and your partner recognized self and other as being involved together out of free choice, or ***volition***. This freedom of choice was perceived by one for the other and also for self. Indeed, the fact of each choosing freely helped invite a sense of special choice.
2. Second, you both were involved ***mutually*** in sex - i.e., you were both on the "same side of the fence at the same time." Again, knowing of both being on the same side of the fence "fed" rather than "starved" your desire to be with each other.
3. Third, both partners' experience was in the domain of ***arousal*** - both

- emotional and physical - the type of arousal that neither you nor your partner need worry about the other's - each seemed fully experiencing their own arousal. In fact, your partner's arousal helped feed yours and vice versa.
4. Fourth, these experiences and actions were occurring in a context of mutual personal **vulnerability**. Each could be as open with her or his physical and emotional experience as was valued.
 5. Fifth, the vulnerability occurred within **knowing trust**; trust that one's partner would not take advantage of, make fun of, abandon, or be abusive of one's own openness.

How well did I guess? Most people find that these five words do describe their best experienced and their best hoped for sexual experiences.

These five words together make the personal events sexual or “sexy”; but if you and a partner do not experience all of them together, the sexiness is missed and the genital event becomes less than best or less than hoped for, in fact, can easily become not sexual at all such as when all five words are missing in assault, or three are missing in duty. The words can be grouped (see figure 1) into *loving responsibility* - ensuring mutual free choice and that the activity, along with its intended experience, is mutual; *selffulness* i.e., that one takes personal responsibility for one's own arousal. I have come to call this personal responsibility and personal immersion into one's own experience while freely sharing with one's partner, selffulness. I do this to distinguish it from selfishness - personal pleasure at the expense of one's partner; and finally *loving intimacy* - the emotional experience of mutual vulnerability coupled with valid trust. There can be other words added to these five to make the sex exceptional and more unique; for instance, when a sense of mutual love in a romantic sense can amplify the depth of the experience. A feeling of commitment in itself can also enhance the sense of sexual safety, as long as it is there for both. However, these latter two “words” are not truly necessary, although when present they do amplify the sexual pleasuring even more.

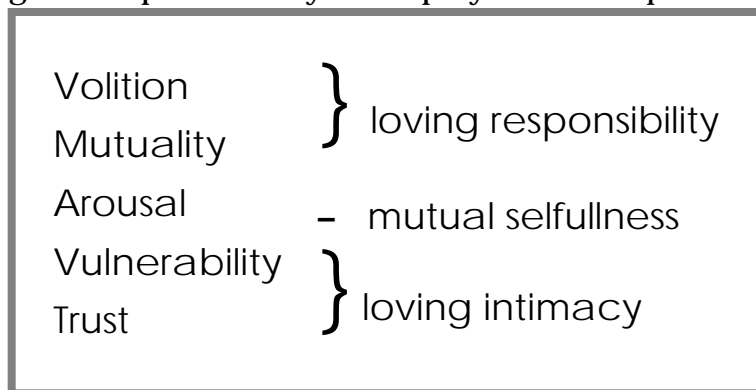


Figure 2 - Five Sexy Experiences

By thinking of people's intended sexuality from such an experiential frame, therapists can invite the clients into better being able to realize their intended lovemaking. If, on the other hand we simply continue using the age-old, worn-out, and most importantly, non-mutual behavioural definitions of sexuality, we risk inviting clients into simply trying yet again to perfect what thousands of generations of humans haven't managed - mutual sexuality based on an inherently non-mutual opportunity!

I had hoped that Robert would, over time, come to value the experiences described by these “five sexy words” as more indicative of the experience that he seemed to be after, rather than his efforts in enacting specific (escalating) sets of behaviours (the paraphilia) which he had traditionally been using. It was both the therapist’s job and the mandate of the Program staff to help residents, including Robert, to recognize that, for instance, genital activity between a prostitute and her ‘john’ entails only mutual choice and mutual judicious trust, but in fact they are not sharing the same kind of experience, since one is preoccupied with business and management of that business and the other with the illusion of sex. They are not having mutual arousal since the prostitute recognizes arousal takes time and time is money, and they are not equally open about these experiences, particularly the prostitute for fear that she would slow down her client’s response and therefore the turnover of her business. Or, for instance, duty-filled obligation between two persons, even when done on a loving basis, has more in common with the business of body selling, than it does the experience of mutual sexuality. And finally, this point is most clearly dramatized by the experiences of those experiencing a sexual assault. For instance, in Robert’s case where he had all the choice and his sister had no choice in the attempted intercourse. Here there was no mutuality. There wasn’t similar arousal, nor similar openness, nor was there any trust. So, not one of the five words applied, and yet for eons people have thought of genital assault in some sexual manner.

By refocusing on Robert’s personal sexual developmental goals towards these shared sensual-erotic experiences, rather than specific behaviours, he came to have a much more potentially effective goal - one of sexual sharing rather than selfishness.

b. Thoughts do not predict actions

The second fundamental premise that was helpful was to have a clear distinction between the differences of thought and of action. Although this sounds quite simple initially, when it comes to the areas of sexuality, many of us, whether professional or lay persons in the community, act as if one is necessarily predictive of the other. For instance, this is often the case in our reflections about paedophile fantasies. We, as a community and often as professionals, become sufficiently alarmed at persons’ fantasies towards children that we become more social control agents than therapists. This is certainly evidenced by Robert’s experience, for as soon as the previous Program’s staff became aware of his “diaper thoughts” they became ever watchful for his “inevitable” action. By inviting both professionals and Robert into continuing to make the connection between the prediction of thought to the feared action, the action was, unfortunately, inevitably produced. However, when Phoenix staff suggested he continue with the thoughts but redirect the action from actual use of soiled diapers or soiled underwear to the thoughts of the soiling while doing a different action, self stimulation in private, we found that over a period of two months, the dramatic behaviours began to recede just as dramatically as they had been present. Robert was able to come to accept his “bizarre” thoughts as simply mindful events, without necessary follow through in specific action. He actually told me once quite clearly that the thoughts worked better when solely in mind than when he had ever acted them out!

c. Violence as Imposition

The third distinction that I had wanted the staff to help Robert to learn was the

awareness of an experiential understanding of imposition and violence in contrast to the experiential understanding of love. Humberto Maturana (1986), a neurophilosopher from Chile who started life as a biologist, has offered very helpful definitions of love and violence. He defines love⁶ as:

“the providing of space (a context of acceptance) for the experience of another even if there is some cost to self.”

And he sees violence as:

“the holding of an opinion to be true such that another’s is untrue and *must* change.”

It is important to realize that the holding of different opinions does not necessitate violence, but rather the holding of the belief that the other’s opinion must change is where Maturana believes all violence stems from.

This is a broad and inclusive definition of violence, but as a psychotherapist, I have found it particularly helpful because it defines as violence even those activities that sometimes cultures value, such as obligatory schooling for children against their wishes, or occasions of punishment at home where a parent’s will is imposed over that of a child. By defining these current culturally appropriate interactions as violent, it invites us as parents, staff, or therapists to acknowledge our own violence and secondarily to develop what is an highly important therapeutic skill - the ability to reflect on our actions. As a therapist use of such a broad definition can invite us to reflect on whether we in fact are acting with *unintended* therapeutic violence in reference to our clients. And finally, this definition can also assist us help clients avoid unintended imposition in relation to the persons whom they care for and love.

The usefulness of this definition of violence as an experience (rather than simply a series of actions) becomes more obvious in describing what I have come to call “The Baseball Metaphor” (Sanders 1986). This intervention can be used either with the victim of genital assault or abuse or with the perpetrator to help him or her to empathically understand the experience of the victim not matter what the intent of the genital activity:

“Let’s pretend for a moment that you are in a baseball game. You’re the catcher and it’s the last inning of the game with the last batter up. The batter has one more strike before being out and if this batter goes out, your team wins. Let’s pretend that this is a fun game between two teams on a Sunday afternoon. Both teams have been enjoying themselves and

⁶In *Love and Limerance (1979)* Dorothy Tenov introduced the word "limerance" to describe the state of falling in love or being romantically in love. As described by Tenov, the basic components of limerance include: 1) intrusive thinking about the desired person; 2) acute longing for reciprocation of feelings and thoughts; 3) buoyancy when reciprocation seems evident; 4) a general intensity of feelings that leaves other concerns in the background; and 5) emphasizing the other's positive attributes and avoiding the negative. Tenov includes sexual attraction as an essential component of limerance, but admits exceptions. Sexual attraction alone, however, is not enough to denote true limerance.

are looking forward to the end of the game so they can move on to celebrate. As the pitcher throws the ball, the batter swings with great effort, misses the ball, and you, as catcher, catch it. You now know that the game is over, your team has won, and the follow-up party awaits. However, before you can fully recover your balance from the catch, the batter turns and with full and mighty strength, swings the bat hard across your head. If this were to occur, would we call this baseball?”

The client usually looks at you, eyes wide, obviously thinking and says “No.”

“I’m curious then, why would it be that if a man uses his genitals *against* a woman, would we call it sex?”

This simple *baseball metaphor* can allow a client (and staff) to both cognitively and experientially recognize and begin to internalize more useful distinctions of the sexual assault than that which society has previously offered. The intervention can then also become available for the helping professionals - those who read the progress notes, who talk with the staff in attendance, and who would talk with the clients themselves.

d. The tyranny of cultural conditioning

The final distinction that I have found particularly helpful is recognizing that in the end, all these distinctions are culturally based, and contrary to these less common understandings I am outlining here, the most common way of understanding problems is to internalize them to persons. For instance, even the English language orients people this way. The phrase “you made me...” gives attribution to the internal experience of another’s intent, or the phrase “you are too horny” implies that horniness is internal to the person as opposed to a product between the two. Michael White (1986) has been a pioneer in using externalization techniques, primarily with families and children; However, I have found these techniques to be exceptionally useful to externalize certain culture practices that have “victimized” clients and thwarted their intent for a more mutual experience of sexual engagement. For instance, I frequently use the idea of patriarchy or traditionalism having “gotten hold of” an individual in ways that are, of course, gendered, but nevertheless limiting of his or her intent. Robert was helped to externalize the feelings of helplessness and hopelessness in relation to his fetishistic activities through becoming the “boss” of his thoughts rather than the thoughts “bossing” him. This not only helped to reverse the feelings of hopelessness and personal despair (feelings that had only fed the need for some form of anxiety reduction - usually through efforts at more elaborate self stimulation with diapers), but also provided Robert with a sense of personal influence and mastery.

e. The larger system influence

If the treatment milieu focuses on “power over” the symptoms or behaviours that lead the clients to our programs, we inadvertently “de-skill” the individual from becoming his or her own “boss.” By privileging the above treatment distinctions, implementing them program wide, helping staff escape their own “cultural biases” in understanding sexuality (i.e., escaping the tradition of behavioural understandings and moving on to more experiential understandings), a treatment milieu is constructed that becomes a

more healing “culture” than that which the client had been previously immersed.

The milieu of Phoenix with eventual open disclosure by Robert of his history of paraphilism within the peer group context destroyed the power of the supposedly “shameful” secret over the definition of his life by having experiences of personal acceptance despite the fact of his oddity of behaviour.

In contrast to the involuntary looks of disgust or disapproval when Robert’s case history was first being discussed among Program staff, mention of his name now brings smiles and laughing remembrances of his efforts, successes, and continued growth.

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