male fetus in the fetal position measuring crown to rump 8.5 inches (21 cm), 13 inches (33.5 cm) in length and weighing 700 grams (1.54 pounds). The head was symmetrical and covered with fine black curly hair." Flanagan has a picture.

There are no absolute standards for determining fetal age but there are averages. The late pediatrician Virginia Apgar has written that the unborn infant is "14 or 15 inches long by the time pregnancy is two-thirds completed," and that it will weigh "a little more than two pounds, on the average, by the end of the sixth month."

The size and weight of the fetus will be important to arguments about fetal age and viability that are expected to come up if there is a trial. The prosecution claims that the fetus was 24 to 28 weeks old, and is expected to use the fact it weighed 700 grams as support for that claim. The defense probably would contest that point and argue that the fetus was only 20 or 21 weeks old and that it weighed only 600 grams at the time of abortion. It would claim that the extra 100 grams, recorded at autopsy months afterwards, were added by the formaldehyde in which the fetus was fixed.

The actual act of manslaughter, described in the indictment as "assault and beating," would seem, in ordinary terms, to be a matter of suffocation. According to the prosecution, after cutting open the mother, Edelin reached in and manually separated the placenta from the uterine wall. So far, so good. This would be medically usual procedure. But then, the allegation is, instead of removing the fetus from its mother, he (i) waited 3 to 5 minutes before taking the placenta and fetus out of her abdomen or (ii) placed his hand in the mother's uterus and compressed the umbilical cord for 3 to 5 minutes, after the hysterotomy had begun and before he removed the fetus. In effect, he is charged with shutting off the fetus's oxygen supply.

The truth of these allegations will have to be determined in court. If it goes to a full jury trial, testimony as to what did or did not happen is expected from persons who were in the operating room. There probably would be testimony from expert witnesses about hysterotomy, with considerable detail about what constitutes usual procedure.

And, it is expected that there would be argument about the viability of the fetus. Had it been "born alive," so to speak, would it have lived, would it have required artificial aid, would it have been mentally damaged?

Flanagan, taking a strict view of the question, believes that it does not matter how long it would have lived outside its mother's body. "God alone knows how long," he says. "Maybe 30 seconds, maybe a lifetime." What he would tell the jury is that it never had a chance because it was murdered after it was physically separated from its mother. He also would present evidence that, in fact, if the fetus was as old as he claims, it might have survived. There are cases of fetal survival at a very early gestational age. It is rare, but some fetuses born at 24 weeks and weighing 1¼ to 2 pounds have made it. Flanagan is busy collecting records of those cases.

Although it is possible to save very young fetuses, it is hardly yet possible to do so routinely and, always, there is a great risk of serious damage to the brain and nervous system. Presumably, the defense would maintain that the fetus could not have survived in any event. A jury may have to decide.

The whole subject of fetal viability is as complex medically as it is legally, and, so far, researchers themselves have been unable to reach a consensus. The questions will get tougher before they are resolved. As progress is made in fetal research, particularly in the rapidly developing area of neonatal intensive care, the viable fetus becomes younger and younger.

Just what will happen with respect to abortion when it becomes routinely possible to save a fetus as young as five gestational months is something society is going to have to work out. And one way it handles these kinds of perplexing problems is through the courts, through the decisions of judges and of juries that may not have a vast store of scientific information at their command but that, nonetheless, are in a position in our culture to make judgments that can affect us all.

It is going to be a tough decision whether it is made by judge or jury.

—BARBARA J. CULLITON

A second article will discuss the antibiotic experiment that led to the investigation of BCH and the indictment for grave-robbing that has been brought against the researchers involved.

Sex Therapy: Making It as a Science and an Industry

The rapid spread of the human potential movement in America today—which encompasses a wild assortment of new techniques, psychotherapeutic and otherwise, for individual self-exploration and the enhancement of the joys of being human—has provided a fertile environment for what may be the fastest-growing field of all—the exploration of human sexuality and treatment of sexual problems.

Sex research, sex training, sex education, and sex therapy programs are blooming profusely around the country, but amid the blossoms there are a good many weeds. People with little or no qualifications are getting into the act—some "educational seminars," for example, offer little more enlightenment than a weekend of dirty movies. There is particular confusion and concern over what constitutes proper training of a sex therapist, and what measures should be taken to curb the abuses that flourish in the name of therapy.

Alfred Kinsey was the first American to pierce through the clouds of puritan ethics and Victorian morality which have shrouded the subject in this country and have exempted it from the mainstreams of scientific and behavioral research. The sex research team of Wil-

liam Masters and Virginia Johnson, who this year celebrated their 20th anniversary of professional association, is largely responsible for giving the investigation of sexuality and the treatment of "sexual dysfunction" credibility and scientific respectability.

Particularly significant is the fact that courses in sexuality have rapidly become standard fare in medical schools throughout the country. This is part of the new humanistic approach to learning in medical schools, where there is less concentration on pathology and more on the whole person. This is also reflected in the fact that more and more students are turning to family medicine rather than to specialties, and that gynecologists are learning to help women gain a better understanding of their own bodies. Also there is a new recognition of the importance of physicians in helping patients and their families face death and dying.

Since Masters and Johnson's second book, *Treatment of Sexual Dysfunction*, appeared 4½ years ago, hundreds of "clinics," "foundations," and "study centers" run by individuals with varying qualifications have sprouted up. Professional intervention in sexual problems is not new—marriage counsellors in particular have been giving advice for years. What is new is that sex therapy has emerged as a discipline of its own, thanks to the discovery that it is possible, with the use of behavioral techniques, to alleviate a sexual problem by focusing on the symptom. This means that it is not necessary to overhaul an entire relationship or personality to achieve successful sexual functioning. The idea is that sexual dysfunction is learned, and, with proper guidance and practice, it can be unlearned. This is in sharp contrast to the traditional psychoanalytic view, which holds that underlying psychological conflicts are responsible for the symptom and have to be straightened out before the sex problem can be eliminated. The virtue of sex therapy, as viewed by its practitioners, is that it is relatively short term, and for many people it can be a low cost substitute for years of psychotherapy, which may fail to relieve the symptoms anyway.

Responding to the rocketing demand for help in sexual problems, a great many people, some clinically trained and some not, have embraced the handy techniques developed by Masters and Johnson and have opened thriving practices as sex therapists. Since offering such services is legal and not unethical by any existing professional code, there is now no way of controlling or even getting reliable statistics on the phenomenon.

There are no official estimates of the number of sex clinics operating in the country today. Masters thinks there are 3500 to 5000, most lacking any institutional affiliation, and only about 100 of which are run by properly trained professionals. Many sex therapy programs are offered by practitioners in medicine and other clinical disciplines whose sex training begins and ends with reading Masters and Johnson, but who offer to treat dysfunction at astronomical prices ranging from $2500 (the standard set by Masters and Johnson who use their fees to support their research program) to $4000.

Then there are sex therapy clinics that are based at universities and teaching hospitals and that are usually part of a broader set of interconnected programs of sex instruction, training, and research. These generally offer the lowest cost services—between $300 and $400 for a course of treatment—to the widest number of people. Their institutional connections generally ensure that therapy will be conducted in a responsible manner by properly trained counsellors.

Since there remains much to be explored and discovered concerning sexual response, it is impossible to define what is legitimate sex therapy other than to say it is that which enhances people's sex functioning and attitudes. Certain practices, such as sexual interaction between therapist and client, are out.

A few programs are briefly described here. There are different roads to the mountaintop, but most start from the base camp established by Masters and Johnson who, in these telescoped times, have already become to sex therapy what Freud is to psychotherapy.

Masters and Johnson believe in the man-woman therapeutic approach, preferably with one member of the team a physician and the other a behavioral scientist. They deal only with couples (although they can be homosexual as well as heterosexual), and during an intensive, expensive, 2-week program with the couple quartered in a hotel in St. Louis with nothing to distract them from their homework—"sensate focus" exercises that are the core of the treatment—the problem is zeroed in on. Unlike mental health professionals who are also trained as psychotherapists, they deal with the dysfunction* and if psychiatric problems are apparent, they are then referred to a therapist.

Helen Singer Kaplan, psychoanalyst in the psychiatry department of Cornell Medical Center and head of the sex therapy unit at New York Hospital, is well known for her work in placing sex treatment more firmly in a psychiatric framework. She has expanded techniques developed by Masters and Johnson and adapted them for use on an outpatient basis. She deals with individuals as well as couples, uses group techniques—one example being a group of husbands and wives working on the problem of premature ejaculation. Rather than driving solely for symptomatic relief, the program deals with emotional problems that have disabled marital communication. Kaplan believes her philosophical model—the integration of behavioral sexual tasks with psychodynamics—has implications for the whole field of psychiatry because it shows how behavioral and analytical techniques can be complementary rather than discrete alternatives. Kaplan is also involved in the training of sex therapists, all of whom must be skilled psychotherapists to begin with.

On the other side of the country, in Long Beach, California, are the team of William Hartman, marriage counsellor and sociologist, and his associate Marilyn Fithian. This pair is regarded by some as the "Masters and Johnson of the West Coast." They run a private therapy and training outfit called the Center for Marital and Sexual Studies. Starting with a basic Masters and Johnson approach, they have added a number of twists, including films of people having healthy sexual interactions, hypnosis, and a "sexological" exam, where a couple is given detailed guided tours of each other's bodies. The pair also conducts a 6-week training program for dual therapy teams, and they make periodic tours around the major cities of the nation offering 1-day lecture-and-film seminars.

One program that is generally held in high esteem by sex people is the Sex Advisory and Counselling Unit at the University of California Medical Center in San Francisco. There, attempts are being made to tailor therapy to the limitations of low-income people,

*Dysfunctions are defined as impotence, premature ejaculation, retarded ejaculation, inorgasmic potential in women, vaginismus (constricted vaginal muscles), and dyspareunia (painful intercourse).

and people who can't take much time off from the job. Work is also being done with groups of inorgasmic women, which combines women's movement consciousness-raising with new sexual awareness. This program is part of a major trend in the field—an effort to make responsible sex therapy available to the needy and not just those who can afford the exotic prices charged by private practitioners. The main schism in the field, in fact, is not so much the matter of correct approaches to dysfunction, but between private practitioners and those who work in connection with institutions. The academics think the private operators are too often ill trained and high priced, and they look askance at fancy brochures sent out to advertise treatment programs and seminars.

Another approach that deserves mention is that developed by Ted McIlvenna, a clergyman, sexologist, and psychologist at the National Sex Forum in San Francisco. This organization takes an educational approach, says McIlvenna, in the belief that sex problems should not be regarded as pathological but as manifestations of negative attitudes and misinformation. So the

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House Renounces Major Reform of Committees

The House of Representatives has renounced the opportunity to make the first major change in committee jurisdictions in 28 years, with many liberal congressmen defending the status quo as determinedly as the most resolute conservatives. Congressmen of all stripes and the various lobbying groups with whom they identify have, in effect, united to resist changes in the familiar pathways of influence and power.

In early 1973 the House established a "select committee on committees" chaired by Representative Richard Bolling (D–Mo.). This past April, the Bolling Committee, made up of 5 Democrats and 5 Republicans, issued its final report, and many members found it threatening. For one thing, it would have confined each member to service on a single major committee, whereas many now serve on two important committees. For another, the report called for consolidating jurisdictions in several fields—notably, energy, environment, transportation, health, and research. This would mean much reshuffling among committees, with some faring much better (or worse) than others.

After several days of floor debate, the Bolling proposals were rejected by the House on 8 October in favor of a gentle alternative put forward by a Democratic Caucus committee headed by Representative Julia Hansen of Washington. By and large, this has left committee jurisdictions unchanged. There are two major exceptions however.

One is that the new Committee on Science and Technology to be established next January will have a jurisdiction broader than that of its predecessor, the Committee on Science and Astronautics. The old committee has had jurisdiction over the National Science Foundation, the National Bureau of Standards, the National Aeronautics and Space Administration, and certain emerging areas of interest such as technology assessment.

The new committee will retain all the above and will acquire from 4 other committees—Interior, Commerce, Public Works, and Merchant Marine and Fisheries—all R & D programs related to civil aviation, environmental protection, and energy (except nuclear energy). It would also be empowered to exercise special oversight over *any* nonmilitary R & D activity, regardless of which committee may exercise legislative jurisdiction. The other major jurisdictional change is that the old Public Works Committee will become the Committee on Public Works and the Environment, with jurisdiction over urban mass transit, civil aviation, and inland waterways.

The Committee on Energy and the Environment proposed by the Bolling Committee would have assumed jurisdiction over programs now scattered among the Interior, Public Works, Commerce, Merchant Marine and Fisheries, and Atomic Energy committees (the last being a joint Senate-House committee). It drew fire from all sides, and not least from such lobbying groups as the Sierra Club and Environmental Action.

Ironically, one of the two Bolling Committee members who actually drafted the reform proposals was Representative Paul Sarbanes (D–Md.), who in 1970 defeated Representative George Fallon, then chairman of the Public Works Committee and one of Environmental Action's "Dirty Dozen." Although establishing an Energy and Environment Committee could be a step toward rationalizing energy and environmental programs, the environmental lobbyists felt—perhaps with reason—that such a committee would quickly fall under the sway of the energy industry.—L.J.C.

Congress Passes Energy Reorganization

The Energy Reorganization Act of 1974, which abolishes the Atomic Energy Commission and sets up separate agencies for energy research and nuclear regulation, was passed by Congress just before the Columbus Day weekend. President Ford was expected to sign the act almost immediately.

The final version emerged after a long Senate-House conference tussle starring Representative Chet Holifield (R–Calif.), chairman of the House Government Operations Committee, who played the blocking role. He resents the de-emphasis of nuclear power the reorganization involves, and was particularly antagonistic to a section in the Senate bill that would have compelled the new Nuclear Regulatory Commission (NRC) to make financial aid available to some intervenors in nuclear licensing and other regulatory proceedings. The reimbursement scheme, which had broad support within Congress, would have allowed the five-member commission discretion to decide who was eligible for financial assistance and how much each would receive. It was designed to mitigate the "David and Goliath" relationship between intervening citizens' groups and utilities.

Also defeated in conference were two related amendments offered by Senator Lee Metcalf (D–Mont.) that would have broadened accessibility of information to concerned citizens. One would have lifted exemptions to the Freedom of Information Act as they apply to information on safety systems and their component parts. The other would have allowed intervenors to obtain relevant studies and reports in particular licensing proceedings. Disgusted with the conferees' inability to reach compromises

National Sex Forum has developed a multimedia blitz weekend program for "sexual attitude restructuring." Anyone can come (it costs $75 per couple). They sit around on pillows and are subjected to simultaneous slides and movies accompanied by running explanations from a staff member. Every possible sex practice—including bestiality, sadism, masturbation, and practices of other cultures—is depicted and discussed at length. That is "desensitization." Viewers go home somewhat appalled, says McIlvenna, but then they sleep on it and end up thinking "so what." So they come back for "resensitization" the next day, where with more movies and talks they find out how good and normal sexual expression is. Individuals and couples can then come back and work out a program to cope with their particular problems.

The National Sex Forum makes its own films which it distributes to hundreds of institutions, including medical schools, here and abroad. The use of films, both pornographic ones and ones depicting sexual anatomy and activity, has become standard fare in training, education, and therapy. They are used widely in medical schools, where courses on sexuality, unusual a half a decade ago, are now routine. They are particularly useful in changing people's attitudes toward sex, a function which a recent survey showed is probably the primary goal of sexuality courses in medical school. Most doctors are not only unskilled in confronting a patient's sex problem, but many are too uptight about the subject to try. James Maddock, who runs the human sexuality program at the University of Minnesota medical school, suggests that physicians have particularly high anxiety levels when it comes to sex because of the type of personality that is drawn to doctoring. Many have "obsessive compulsive" personalities which make it difficult for them to deal with an emotion-laden and ambiguous subject that requires a tolerant, sensitive, and, above all, relaxed approach. They also find it difficult to explore the subtleties of sex relationships when they are keyed up to making daily life-or-death decisions, he notes.

Harold Lief, who heads the 6-year-old Center for the Study of Sex Education in Medicine at the University of Pennsylvania, is a pioneer in sex education for medical students. In the early 1960's, he says, only three schools offered any instruction in sexuality. In 1968 there were 30. Now, according to a survey he recently completed with his colleague David Reed, 106 of the country's 112 medical schools teach it, and in 60 percent of these the courses are required as part of the core curriculum. Medical students overwhelmingly favor such courses, the survey finds, and are even more enthusiastic about them than faculty members. The content of the courses includes instruction on normal sexual behavior, its variations and deviations, sexual disorders, psychosexual development, and treatment of disorders, including rudimentary counselling skills. Half the schools invite spouses or "significant other partners" to attend with the students. While sex instruction is particularly relevant to the fields of gynecology and psychiatry, new emphasis is also being placed on counselling people partially disabled by disease (diabetes, for example, can produce impotency), heart attacks, operations, or advanced age. A cardiac patient, for example, is no longer vaguely told to "take it easy," but is treated to a frank discussion of safe levels of exertion. Old people also stand to benefit. Despite Masters and Johnson's affirmation that sex can enhance life up to the last minute, a recent study of doctor-patient relationships showed that most physicians felt inadequate when it came to dealing with sex and the senior citizen, that most of the doctors regarded it as "unimportant," and even gerontologists agreed that for old people it was "just a memory."

Of all the sex projects springing up across the land, one of the newest, and most ambitious sounding, is the research, therapy, and training program being set up at the State University of New York at Stony Brook. The impetus has come from Stanley Yolles, head of the department of psychiatry there and former head of the National Institute of Mental Health, where, before his departure several years ago, he unsuccessfully sought to establish an in-house sexual research project. Yolles has been gathering together an interdisciplinary team of educators, clinicians, and researchers with the object of establishing an "international academy of sex research," a mecca for sex researchers from around the world. At present, according to Joseph LoPiccolo, head of the sex therapy and research unit, Stony Brook is one of very few places where research is being done on new behavioral techniques for alleviating sexual dysfunction. LoPiccolo is well known in sex circles for his explorations of the potentials of masturbation. His innovations include a detailed program of masturbation for inorgasmic women, and a routine, involving pornography and masturbation, that has enabled homosexual men to respond sexually to their wives. (To LoPiccolo's surprise, these men, rather than learning to favor women as sex partners, learned instead to become firmly bisex-

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on any of these issues, Metcalf refused to sign the conference report.

Most of the other differences in the House and Senate versions were resolved in the Senate's favor. These included provisions to prevent a pronuclear bias in the new Energy Research and Development Agency (ERDA), to promote energy conservation and environmental protection in ERDA, and to tighten safety regulation (for instance, the NRC will have to make public immediately any safety-related "abnormal occurrences" at nuclear power plants).

The Joint Committee on Atomic Energy (JCAE) will be losing much of its sway on energy matters. In the House, ERDA (with the exception of its atomic energy component) will be overseen by the expanded Committee on Science and Astronautics, to be known starting next January as the Committee on Science and Technology. In the Senate, jurisdiction may be scattered among several committees. The NRC will be under the jurisdiction of the JCAE.

Passage of the energy act comes on the heels of President Ford's announcement that Interior Secretary Rogers C. B. Morton, who once briefly headed the White House Domestic Council's energy committee during the days of revolving energy czardoms, will head a new national energy board and serve as "overall boss" of the nation's energy program. Thus it appears, assuming the era of continuous shuffling and reshuffling of energy policies is past, that the framework has been laid for the country's 10-year, $20-billion plunge toward "energy self-sufficiency."—C.H.

Erratum: A "briefing" pertaining to the law suit in the taconite pollution case which appeared in the 18 October issue of *Science* referred incorrectly to Solicitor General Robert H. Bork's part in the so-called "Saturday night massacre" of last year. Bork dismissed the special prosecutor, Archibald Cox, but he had no role whatever in the dismissal of Attorney General Elliot L. Richardson and his deputy, William D. Ruckelshaus.

ual—one indication of the malleability and continuing mysteries of human sexual response.) The Stony Brook group is also developing video cassettes and booklets for at-home use by dysfunctional couples. The effectiveness of this method, or lack of it, will help resolve a still unanswered question of how much can be done by instructional materials and how much needs interaction with a therapist.

While Middle America may quail at such frontal assaults on the privacy and taboos surrounding sex, there are, within the educational, medical, and research establishments, few overt traces of the resistance that met the work of Alfred Kinsey or the early research of Masters.

The chief controversy now going on among those concerned with training and clinical work on sex, and the one that has brought Masters and Johnson out of their laboratory and into such forums as the "Today" show, is the matter of quality control in sex counselling. If sex were a drug, it would top the list of abused substances, so it is hardly surprising that some pretty gross exploitation is going on. Some "sex therapists" treat their clients to sado-masochistic practices, homosexual seduction, sexual participation by the "therapist," and thinly veiled prostitution under the label of "surrogate partners." On a less flagrant level, many academics are distressed about the number of ill-trained private operators who in addition to doing high-priced therapy are fond of running weekend "seminars" largely composed of a barrage of pornographic films that purport to train professionals in sex therapy.

No one is agreed on exactly what constitutes proper training for a sex therapist and there are raging debates on what the proper accreditation and licensing procedures should be. Terminology, too, remains to be sorted out. Some people use the term "therapist" and "counsellor" interchangeably; others say the former deal with deep-seated problems, while the latter are only equipped to deal with relatively simple anxieties and communicational difficulties. There is general agreement that a would-be sex therapist should start with a degree in a discipline requiring clinical and counselling skills and should then undergo a course of specialized training, lasting perhaps 6 months to a year. The obvious candidates for advanced training are doctors, psychiatrists, psychologists, marriage and family counsellors, psychiatric nurses, social workers, and clergymen. Full-fledged training programs (as opposed to weekend or longer seminars and workshops) are now conducted in upwards of half a dozen places, most of them university-based. They include "desensitization," familiarization with variations of sexual functioning and dysfunctioning, methods for dealing with dysfunction, relationship counselling, and supervised on-the-job training. Training facilities nowhere near begin to fill the growing demand for sex counselling, so not even strict legislation would presently prevent unqualified individuals from getting into the business.

The American Association of Sex Educators and Counsellors (AASEC), which has been accrediting sex educators since 1967, plans to become the first organization to accredit sex counsellors, starting in November.

Concern Spreading

Other organizations have started actively worrying. The newly formed Eastern Academy of Sex Therapy, whose membership is mainly drawn from medical schools, will be addressing itself to the questions of proper training and qualification. The National Association for the Scientific Study of Sex will address the issue in its meeting in November. The American Medical Association (AMA) also has a task force on sex therapy, with representation from mental health professionals, which is trying to figure out what the role of physicians should be in seeing that clinics have appropriately trained personnel and programs. Masters, who compares the state of affairs now ("god-awful") with medical education at the time the Flexner report came out in 1910, is pinning his hopes on the AMA committee to make recommendations that will guide states in proposing licensing law for sex therapists. Many observers think it is too soon for one organization, such as AASEC, to set itself up as the arbiter of what constitutes adequate qualifications. Others think accreditation by a private organization doesn't mean much and that it is up to states to develop licensing procedures.

Everyone thinks things have to get organized, not only for the protection of the public and the integrity of the field, but so that people will be able to obtain insurance reimbursement for sex therapy. Currently, insurance carriers will not reimburse any "relationship" counselling, whether it is marriage counselling or 2 weeks at Masters and Johnson's. Reimbursement is generally available if sex therapy is done by a qualified health provider, provided that the diagnosis is something other than sex dysfunction. This leads to some silly dilemmas—one Washington-area psychologist who is also a trained sex therapist says her patients never had trouble getting reimbursed until the insurance carriers found out her specialty. They don't want to pay for the sex part so "they ask in each case whether sex therapy was involved." She finds this differentiation absurd. "A person who is not healthy sexually is not a healthy person." The status of sex therapy, like that of clinical psychology, will probably remain murky until national health insurance rolls around.

As the clouds of Victorianism and misinformation continue to lift, it is becoming increasingly apparent that sex therapy, while hardly a life-or-death matter, can contribute significantly to emotional health. One's sexual identity, after all, is inseparable from one's identity. Some people, who function reasonably well themselves, may regard sex therapy as a luxury, perhaps even decadent, but as any sex counsellor will testify, the amount of sexual misery across the land, suffered in secret because of guilt, anxiety, shame, ignorance, and the belief that "that's how things are," is incalculable. Masters and Johnson estimate that 50 percent of married couples (and by extension, all people) suffer from sexual problems that significantly affect the relationship. While many are the logical products of rotten relationships, others—learned responses from the past—can poison good ones.

James Lieberman, a Washington, D.C., psychiatrist who also does sex therapy with married couples says: "The nice thing about sex therapy is that it involves touch, intimacy, vulnerability, and trust. Many people have never experienced these in childhood. A great many of the adults walking around today are probably incapable of genuine intimacy because their parents had been themselves deprived of love in their early years, and didn't know how to transmit it to their children. Hopefully this picture is changing because now for the first time, thanks to contraception, most children born were planned and are wanted. There is no way to learn intimacy just by talking or reading books, you have to learn it by early experience, education and practice."

—CONSTANCE HOLDEN