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THE CHALLENGE OF DIVERSITY

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THE CHALLENGE OF DIVERSITY

FEATURES

DEPARTMENTS

FROM THE EDITOR

SEXUALITY EDUCATION AND DIVERSITY:
Meeting the Challenge

Dore Hollander

The signs are everywhere: in the listings of course offerings in college catalogs; in museum exhibitions, and even in the focus of entire museums; in the restaurants lining the streets of New York and other major cities. Americans in growing numbers encourage diversity. We seem to thrive on exploration, to live for challenge—to our worldviews, our aesthetics, our taste buds.

Americans' fascination with the different sometimes disappoints, however, as it often does in the area of sexuality-related education. Somehow, when it comes to teaching young people about sexuality issues, or to addressing the needs of persons with HIV/AIDS, many programs designed to serve diverse communities have by and large treated their audiences as though they were monolithic. With the best of intentions, they have labored toward the goal of disseminating a certain amount or certain type of information, under the assumption that everyone will get it—more or less.

But it is just not as easy as that. Differences in social and cultural environments create differences in attitudes, behaviors, expectations, and needs.

As Herbert Samuels points out with regard to myths about African-American sexuality (page 3), for example, the historical experiences of a racial group affect the values and self-understanding—and hence the behavior—of its members. For sexual health professionals to work effectively with individuals in a particular group, it is imperative that they learn about those experiences; without such knowledge, they cannot begin to address current issues in ways that are relevant and sensitive to the population in question.

Furthermore, some cultural groups have had difficulties addressing their own needs in the ways that would most benefit them. High levels of acculturation—whether achieved voluntarily or accepted with resignation—have stifled their voices or denied their heritage; lack of training or of a sense of empowerment has prevented them from speaking with the insight they assuredly have or the authority they may not realize they possess. Sharon Day, writing about the experience of American Indians (page 6), contends that it is important for members of a group to understand themselves, and to build on their self-understanding, in the context of their traditional culture.

And diversity does not refer only to differences according to race. In fact, as Kay Armstrong argues (page 8), race has limited reliability as a characteristic by which to classify people for purposes of predicting or describing sexual behavior. (Indeed, as she demonstrates, it is often not even clear just how to define various racial groups.) People can also be categorized, for example, according to age, gender, socioeconomic status, religiosity, sexual orientation, marital status, physical abilities, access to health and education services, and the desire for children. And some of these classifications are more meaningful than race. The implication for researchers, policy makers, and program planners is that in seeking to identify problems with and opportunities for sexuality education, they need to look at a variety of factors that influence sexual behavior. The implication for sexuality educators is that they have to understand and be able to address those factors.

Dealing effectively and respectfully with people from a wide variety of backgrounds is no small task for educators and health care professionals concerned with sexual health. It requires access to proper training materials—culturally sensitive curricula and guidelines, workshops, and audiovisual resources. At least as important, working well with diverse populations entails an understanding of what constitutes culture, scrutiny of one's own background and how it has influenced one's assumptions about a range of issues, and sensitivity to what is important to the individuals one is seeking to serve. These principles are embodied in Advocates for Youth's comprehensive framework for building "cultural competence," part of which is described in this issue (page 11); the model rightly stresses that this is a long-term process.

Preparing to educate diverse populations can be an enlightening experience for professionals. Receiving culturally sensitive education can be a transforming experience for young people. There was a time when universities did not offer courses in "international and intercultural studies"; when museums were not dedicated to the people of Tibet or the history of the American Indian; when the local restaurant served only meat, potatoes, and apple pie. Things are different now, and we are all better off for the change.

SEXOLOGY, SEXOSOPHY, AND AFRICAN-AMERICAN SEXUALITY:

Implications for Sex Therapy and Sexuality Education

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The sexual behavior of African-Americans has long been a source of fascination for white society. This fascination, which stems from a belief that African-American sexual behavior is somehow more sordid and crude than the sexual behavior of white Americans, is by no means a new concept. Reports dating from the mid-sixteenth century attempt to depict the sexual behavior of Africans as bestial. The same descriptions were later applied to the Africans brought to the New World by the slave trade.[1] Pediatrician and medical psychologist John Money would characterize these descriptions as sexosophy, or the philosophy of sex, rather than sexology, or the science of sex.[2] Eminent psychologist and personality theorist Kurt Lewin would consider them the speculative phase of scientific inquiry, namely, conjectural theorizing without empirical data.[3]

Lewin suggests that science matures over three distinct periods—the speculative, the descriptive, and the constructive phases. The speculative phase is an attempt to provide a model to explain the "world around us," or at least certain phenomena present in our world; Freud's *Three Essays on the Theory of Sexuality,* which introduced libido theory, is an example of this phase. The second, or descriptive, phase is a taxonomic enterprise, a gathering of facts that will describe phenomena in a more precise and concise fashion; the two Kinsey volumes represent the middle phase. The third, or constructive, phase emphasizes theory—theory that is grounded in facts obtained through systematic empirical inquiry rather than abstract speculation or subjective theorizing. It is to the constructive phase that sexology must be looking as the twenty-first century approaches.

At first glance, no serious scientist could reject the notion that theory based upon empirical data is an important step toward building better explanatory models. But upon closer scrutiny, this constructive phase applies only to certain individuals within our society—mainly middle-class white Americans. A plethora of information is available regarding the sexual attitudes and behavior of middle-class white Americans. Meanwhile, because of a lack of research focusing on other groups, what we know—or think we know—about individuals other than middle-class white Americans is sexosophy and speculation. Until the recent publication of *Sex in America,*[4] the major surveys on sexual behavior conducted in the past thirty-five years either omitted African-Americans or included them in numbers too small to be statistically significant. This has too often led to interpretation of African-American sexual attitudes and behavior by analogy rather than by way of data taken directly from them. Such interpretation, in turn, leads to the perpetuation, among both whites and African-Americans, of mythological and stereotypical attitudes regarding African-American sexuality that are at best superficial and misleading, and at worst supportive of the racist ideologies of the past.

The Mythology of African-American Sexuality

The myths about African-American sexuality include these recurrent themes: that African-Americans are more animalistic and bestial in their quest for sexual liaison than are members of other racial or ethnic groups; that the penises of African males are larger than the penises of males from any other group; and that this size differential results in a greater reproductive capacity and sexual potency than in other males. But some of the most interesting commentary can be found in the work of late-nineteenth-century anthropological writings, in particular the work of Jacobus.[5]

Jacobus was a surgeon in the French army who served in various colonial outposts, particularly in North Africa during the 1880s and 1890s. As a physician, he had the opportunity to examine the organs of many African males and females. Jacobus wrote that the penis of the "African Negro" was by far larger than that of any other human male group. Indeed, he said the African male's penis looked more like the organ of a donkey than of a man. He described the African Negro as a "stallion man," as distinct from the average European male. The "African Negress," according to Jacobus, had a much larger clitoris than her European counterpart, and a large, insensitive vagina. This observation provided Jacobus with the

rationale that only a "stallion man" could make the "Negress" feel the proper physiological sensations and, similarly, that only the "Negress," with her large, insensitive vagina, could accommodate an organ of such monstrous proportions.

The same characteristics had also been applied to blacks who had been transported to the New World as slaves beginning in the middle of the sixteenth century. The beliefs were expanded upon over the next 200 years by plantation owners who used blacks as breeding stock, and by some of the most prominent people of the day. For example, Thomas Jefferson once wrote that black males seemed to pursue their females more ardently than others.[6] The historical record is replete with images of the salacious, carnal nature of African-Americans.

The sexosophy of the past has become the foundation for the sexology of the future. Since the late 1960s, researchers have reported that according to their data, African-Americans are more sexually "permissive" than white Americans. These studies are difficult to compare because they used different criteria to determine permissiveness. But they do indicate that blacks engage in coitus at earlier ages and are less likely to perform self-masturbation, fellatio, or cunnilingus than whites. Compared with whites, black males are more likely to experience their first ejaculation during coitus, rather than through masturbation, and black females are likely to reach orgasm more frequently in premarital coitus.[7] These findings are usually the basis on which African-Americans are judged to be more permissive than whites.

All too often, whites are the control group to which blacks are compared. If the behavior of whites is used as the standard, then African-Americans become aberrant whites. However, as Philip Belcastro, a professor of health education, rightly points out, if performing fellatio, cunnilingus, and self-masturbation were the criteria for determining permissiveness, then whites would be more permissive than African-Americans, or could be viewed as aberrant blacks. This is more than a game of semantics, because the way in which research data are interpreted depends on who is doing the interpretation and what philosophical assumptions underpin the analysis. Any meaningful investigation into the lives of African-Americans must be viewed from an Afrocentric perspective that takes into account the philosophical assumptions of the people being investigated. Without adequate descriptive data about the sexual experiences of African-Americans, one is left with sexosophical speculation. However, this should not lead one to believe that there is *nothing* to be gleaned from previous studies.

Indeed, if African-Americans, on average, have sexual intercourse at an earlier age, masturbate, and perform fellatio and cunnilingus less often than white Americans, and hold different opinions about sexuality, then it would seem prudent to take these differences into account when providing counseling or education to African-Americans. In other words, what implications may these differences pose for sex therapy or sexuality education?

Sex Therapy

The stereotyped notions about the sexual experiences of African-Americans not only influence the attitudes that whites may have about African-Americans, but also affect the way in which African-Americans perceive themselves. For example, for an African-American male who is experiencing difficulty in maintaining an erection or ejaculatory control, the willingness to seek help may be dependent on how closely the individual identifies with the myth of the "superpotent" black man. Any man may feel embarrassment about a sexual problem, but for the African-American male, the embarrassment may be compounded by the images of the myth.

For clinicians, an awareness of this legacy is essential to treatment. A key component in the treatment of many sexual problems, for example, is the use of self-masturbation exercises, which can be effective in helping a person to learn more about his or her own sexual responses. Many African-Americans may have some negative feelings about self-masturbation that may be at odds with a treatment using this approach. Changing these negative feelings may take more time than is typical for clients who are not African-American. Furthermore, African-Americans who masturbate may be reluctant to discuss this issue because, for many, admitting that they masturbate is tantamount to admitting that they cannot find a sexual partner. Therefore, rather than suggesting self-masturbation exercises as an initial treatment approach, clinicians may suggest masturbation exercises that clients can share with their partner.

Sexuality Education

Certain approaches should be utilized, and certain topics included, in any sexuality education program that purports to address the needs of African-American children.

Many sexuality, or "family life," education programs employ the health belief model not only as a way to predict sexual behavior, but to facilitate behavioral change.[8] This model relies on certain assumptions that are based on Euro-American social norms, which may not be consistent with the beliefs and values of many African-Americans. Psychologists Vickie Mays and Susan Cochran correctly point out that these kinds of attitude-behavior models "assume that people are *motivated* to pursue rational courses of action. They further assume that people have the *resources* necessary to proceed directly with these rational decisions....black Americans confront an environment in which much of their surrounding milieu is beyond their personal con-

trol. Models of human behavior that emphasize individualistic, direct, and rational behavioral decisions overlook the fact that many blacks do not have personal control over traditional categories of resources—for example, money, education, and mobility."[9] What African-Americans do have control over is their own sexuality. Sexual expression, for many African-Americans, becomes a source of power that can lead to a more positive sense of self, as well as a bond to the community at large. For example, Mays and Cochran argue that during the 1970s, blacks saw contraceptive use as a form of genocide advocated by whites. Control over one's reproduction thus had political and social implications in that it was a means to achieve equal rights. For many African-Americans, therefore, educational models that place emphasis on social norms and commitment to social responsibilities may be better predictors of future behavior than those that value individualistic rational reasoning.

In terms of content, emphasis on contraception, sexually transmitted diseases, and safer sexual practices is vital to the education of the African-American adolescent. If African-Americans actually do begin having sexual intercourse earlier than their white counterparts, then education about these topics must begin earlier than is often the case: The third or fourth year of high school is too late. These discussions must take place before sexual intercourse begins—in junior high school at the latest. And perhaps these discussions need a political and social context. In other words, if "contraception equals genocide" was a rallying cry for the 1970s, then this message needs to be replaced with one that recognizes that premature parenthood is not a useful means to achieve liberation in the coming decades.

Conclusion

Understanding the complex role that sexuality plays in the lives of African-Americans requires much more information than is now available about the sexual attitudes and behavior of a broad spectrum of African-Americans. This research should not simply replicate the Kinsey survey methods, but should provide a theoretical framework that does take into account the philosophical assumptions of the people under investigation. Then counselors and educators will be in a better position to judge whether their views about African-American sexuality are correct or in need of revision. Instead of sexosophical speculation, counselors and educators can begin to build a constructive phase of sexology that recognizes, and addresses, the richness of African-American culture.

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SIECUS VISION STATEMENT OF INCLUSIVENESS

SIECUS recognizes that the myriad dimensions of human diversity—including age, race, gender, ethnicity, sexual orientation, physical abilities, and social class—have a profound impact on sexual attitudes, values, and behavior. This diversity contributes to a richer, more authentic understanding of human sexuality and is therefore viewed by the organization as a valuable resource. To ensure that the work of SIECUS benefits all Americans in relevant ways, the organization is fully committed to a policy inclusive of diversity in its Board, staff, and program.

SIECUS Board of Directors
1993

AMERICAN INDIANS: Reclaiming Cultural and Sexual Identity

Sharon M. Day
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Sexuality is a pervasive force in an individual's life. One's sexual identity—including one's understanding of gender roles and the sexual behaviors in which one chooses to engage—permeates one's thoughts, feelings, and behaviors. That identity is shaped largely by the mores and values of one's family and community. Peoples indigenous to North, South, and Central America—commonly known as Native Americans or American Indians—have begun to explore their own definitions of healthy sexual identity and behaviors, in the light of, and with the help of, Native culture.

Historical Perspective

Oral histories and teachings handed down within tribes for millennia have reflected Indians' understanding of sexuality. Tribal creation stories tell that women and men were created simultaneously and were dependent on each other for survival. In Ojibwe creation stories, Sky Woman descended from the heavens and gave birth to human beings, or the *anishinabe.* As descendants of Sky Woman, all women have the potential to give life. Women who choose not to bear children also have gifts related to giving life, and may function as midwives, healers, or dreamers. Males are required to fast and seek solitude in search of a vision to reveal their purpose on earth.

Historically, in Native communities, adults were responsible for child rearing. Every adult was a teacher and cared for the younger members of the tribe. Children were held in high regard, as were older community members. Grandparents often raised the firstborn child in a family, and were responsible for teaching the child about social mores and values, including sexuality, and behaviors that ensured the tribe's survival. Children learned about creation stories, naming ceremonies, spiritual teachings, puberty ceremonies, and spiritual and social songs and dances. They learned about gender roles, some of which were practical, and others of which fell within the spiritual realm. (For instance, men often had to travel, and nursing women could not accompany them; consequently, men learned all the skills that were necessary away from home, such as hunting, even though men and women might otherwise have shared some of these tasks. Meanwhile, women were the ones to bring water to ceremonies and bless it, because water gives life.) Some tribes believed there were three genders: male; female; and *diconidique* or *diconidiniin,* a special kind of woman or man. Today, this third gender would be considered lesbian or gay. Above all, children were taught to respect individuals because every member of the tribe was important. In some tribes, people who were different were accorded respect and admiration; lesbian and gay people were often artists, healers, the givers of names, and spiritual people.

When American Indians began having contact with Europeans, they were deluged with Western attitudes and laws that ignored or were contrary to traditional Native values and behaviors. In some ways, this resulted in forced inclusion. For example, Indian children who lived on reservations that did not have their own schools were sent to boarding schools, many of which were run by the government or Christian missionaries; there, the children were often not permitted to speak their own languages or practice tribal ceremonies, and they may have been punished for doing so. In other ways, this highlighted the differences between the European and Indian communities. For instance, European males viewed themselves as superior to women: European women were considered the property of men, first their fathers and then their husbands. Native communities, by contrast, were egalitarian, and women participated in all decision making that affected tribal life.

American Indian Sexuality Today

In many ways, AIDS has opened the door for a more frank discussion about sexuality in this country overall; it has provided new opportunities for the Native community, as well. The Minnesota American Indian AIDS Task Force—which serves American Indians who are living

The terms "Native American" and "American Indian" are used interchangeably throughout this article. National Indian organizations favor "American Indian" because it is the term used in federal legislation that authorizes resources for Indians. Many urban tribal people favor "Native" because it embraces people from North, Central, and South America.

with HIV/AIDS, many of whom are gay, lesbian, or bisexual—devotes much attention to the exploration of sexuality with clients and with its adolescent peer educators. For people living with HIV/AIDS, this means addressing identity issues, how to negotiate and practice safer sexual behaviors, healing, and reconciliation with their family and community. (The last of these is especially important because tribal people consider the community an extension of the family.) The Task Force uses a variety of approaches in its work.

Peer Educators. The Task Force prepares American Indian adolescents to become peer educators by helping them to understand themselves, their peers, and the community as they struggle to explore their own sexual identities and become comfortable within their bodies. The peer educators, who receive training from the Task Force in such areas as HIV, sexuality, alcohol and drug abuse, and sexually transmitted diseases, lead discussion groups and workshops with other adolescents. And, as the Ogitchidag Gikinooamaagad Players, they perform plays about AIDS in high schools and for Indian audiences. (*Ogitchidag* means "warriors" in the Ojibwe language, and *Gikinooamaagad* means "teachers"; hence, this is a fitting name for these educators/actors.)

Drawing on Native Culture. Among the activities the Task Force uses to help both clients and peer educators explore their sexuality are role-plays, storytelling, ceremonies, art therapy, and guided meditations. Programs are conducted by spiritual leaders; therapists; artists; and the Task Force's own staff, Native health professionals from various tribes, including individuals who identify as heterosexual, gay, or lesbian.

One approach the Task Force uses is teaching songs, which are included in plays or in ceremonies. Certain songs are sung only by women; these are ancient songs derived from ceremonies and sung for healing and purification. Others are sung by women and men; these are social and generally pertain to relationships.

Another approach involves clients in making dance regalia for social dancing at powwows. For individuals who have been estranged from the community, this activity is a way to reconnect with the social life of the Indian community. For gay men and lesbians, who may combine male and female attire in their dance regalia, these outfits serve as an expression of sexual identity.

Conclusion

One's cultural and sexual identities ought to be a source of strength. In this country, the effects of racism and heterosexism have had damaging effects on people of color and gay men and lesbians. For too long, Indians have been taught to be ashamed of who they are, and have been forced to adopt the dominant culture's attitudes and beliefs. It is time for Native Americans to reexamine and reclaim their cultural and sexual identities, and throw off the stereotypes and Western ideologies that do them harm. The creation stories, songs, and social protocols of tribal people have enabled them to survive hundreds of years of racist and genocidal practices; it is time for Native communities to reclaim traditional ways to restore the health of their members.

SURGEON GENERAL'S TENURE ENDS ABRUPTLY: SIECUS COMMENTS

On December 1, 1994, World AIDS Day, Surgeon General Joycelyn Elders responded to a question by saying, "As per your specific question in regard to masturbation, I think that is something that is part of human sexuality and it's a part of something that perhaps should be taught."[1] Using this comment as an excuse, the White House announced on December 9 that she would be relieved of her duties as of January 1. White House Chief of Staff Leon Panetta, who announced that President Clinton had demanded and received Elders's resignation, said that "there had been a number of statements where the president has disagreed with her views and this is just one too many."[2] In his statement, President Clinton said, "Dr. Elders's public statements reflecting differences with administration policy and my own convictions have made it necessary for her to tender her resignation."[3]

SIECUS Executive Director Debra W. Haffner remarked, "Dr. Elders has been an outstanding spokesperson on the need for young people to have accurate information; comprehensive health education, including sexuality education; and reproductive health services. She will be sorely missed."

Professionals in the sexuality field hope that Elders's replacement will have a similar commitment to speaking out on the issues that directly affect sexual health. The White House has yet to name a successor. The irony is that a new nominee will need to be approved by the new Republican-dominated Senate. Questions about the nominee's positions on abortion, sexuality education, and family planning are likely to be central.

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THE PROBLEMS OF USING RACE TO UNDERSTAND SEXUAL BEHAVIORS

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With the onset of the AIDS epidemic, social science researchers have intensified their efforts to define and understand unsafe sexual behaviors. Recent increases in sexually transmitted diseases (STDs), as well as increased sexual activity among young adolescents, have also contributed to the heightened interest in sexuality studies. These studies seek to define characteristics associated with specific behaviors, usually sexual practices that raise the risk of infection with an STD, including HIV, or of an unintended pregnancy. Risky sexual behaviors include having multiple sexual partners, exchanging sexual activity for drugs or money, and having unprotected intercourse. A better understanding of individuals who engage in both safer and unsafe sexual behaviors can help professionals in sexuality-related fields to develop and implement interventions that foster healthy sexual behaviors.

Social science research frequently points to race as a defining characteristic of populations with unsafe sexual behaviors. Such large-scale surveys as the National Longitudinal Survey of Youth, the National Survey of Families and Households, the National Survey of Family Growth, and the Youth Risk Behavior Survey contrast racial groups by sexual risk-taking behaviors. The populations sampled are typically analyzed by subgroups based on race and described in terms of their relative risks; for example, a study may document that members of one particular racial group appear to be more likely than others to have an unintended pregnancy or a sexually transmitted disease.

But how valid and useful is race as an indicator of sexual behaviors? The benefits of using racial groupings have not been proven. For decades, scholars have debated how meaningful race is as a predictor of social behavior.[1] Some state that using race to define a set of behaviors could lead to more harm than benefits by promoting faulty assumptions, even stereotypes. Others feel that assessment of racial categories is needed for political reasons, to measure change in correcting injustices to specific racial groups.

Difficulties in Defining Race

The term "racial group" generally denotes a category of people with a distinct set of physical characteristics that are innate; the assumption is that each racial group differs from other groups in these physical characteristics. Furthermore, identification with a racial group assumes that all its members have the same heritage. This is rarely the case, as an examination of federal classifications shows.

Since 1977, the Office of Management and Budget has identified Americans in five broad racial categories—American Indian or Alaskan Native, Asian or Pacific Islander, black, white, and other. However, Native Americans can belong to a tribe with 25 percent Indian ancestry. Some tribes define a member as someone with as little as one-sixteenth blood quantum, which means that fifteen-sixteenths of the individual's heritage may lie in other races.[2] The category Asian or Pacific Islander includes nine nationalities, and two others may be added. Until recently, the "one drop rule" meant that as little as one drop of "black blood" defined a person as black.[3] Of the individuals who classify themselves as black, approximately 75–90 percent are of multiracial ancestry. Whites are also composed of many nationalities and ethnic groups. Controversially, the federal government considers Hispanics an ethnic group, not a race; thus, individuals define themselves by whether or not they are of Hispanic origin. In response to survey questions on race, Hispanics frequently identify themselves as "other," rather than checking one of the four specific groups. According to the census, "other" is now the third fastest growing racial group, after Asian or Pacific Islander and Native American.[4]

Clearly, then, using the current racial categories results in groupings that are not well defined. Survey respondents, given the choice of one of only five broad categories, select the one that is meaningful to them at the time. The inclusion of a multiracial category in surveys or generic forms would aid in the accuracy of defining racial heritage. Such a category, however, would not likely increase the usefulness of identifying differences among individuals when it comes to sexual behaviors. Differences within racial groups can be as vast as those among groups.[5]

Politics and government programs often have required detailed information about race for the purpose of special programs for minorities. The civil rights laws in the mid-1960s included requirements of

collecting detailed information about members of minority groups. Some government grants require that applicants identify intended target populations by race and ethnicity. For example, an individual must have 50 percent "Indian blood" to qualify for some federal benefits.[6] Social programs with eligibility based on race instead of on need can create disharmony and inequity by omitting those with similar risk behaviors who are outside the targeted group.

Alternatives to Race for the Social Scientist

Since the validity and reliability of race are questionable, why not eliminate it as a demographic variable for use in describing sexual behavior? Advocates of eliminating racial classifications and using other characteristics to identify groups of people have included the American Civil Liberties Union (which pressed to eliminate the race classification in the 1960 census), paleontologist Stephen Jay Gould (who has proposed identifying people by regional division), and anthropologist Ashley Montagu (who prefers to use "ethnic group").[7]

In reality, race is a simplistic and ill-defined measure of a much more complex set of socially defined behaviors, beliefs, and customs. Other sociocultural and economic measures should be examined that would replace race as a descriptor or predictor of sexual behaviors. In a 1993 address to the American Psychological Association, Gail Wyatt encouraged her colleagues to "advocate for the use of variables that denote ethnic and cultural group identification rather than race...to include additional grouping variables...to identify specific subgroups that are most at risk...examine other psychological factors that influence behavior change among populations at most risk."[8]

Other characteristics relevant to sexual behaviors usually outweigh the effect of race. These characteristics include cultural norms; religiosity; economic measures; and life issues such as the role of forced or abusive sexual relations, the propensity to plan for risky situations, peer norms, and the desire for children; and the amount and kinds of sexual information and public health services available. In one study, race appeared to be correlated to poverty, but controlling for poverty level reduced the differences among the racial groups.[9] In another, race was significantly related to crack and cocaine use, but when the researchers controlled for several sociodemographic characteristics (including socioeconomic status, employment status, and number of moves in the past five years), the differences became nonsignificant.[10] In yet another study, racial differences in nonmarital intercourse among adolescents declined when neighborhood indicators of socioeconomic status were included in the analyses.[11]

Behavioral health models attempt to incorporate psychosocial and other factors in explaining sexual behaviors. None of these models uses race. The most frequently employed behavioral models include such characteristics as expectations; intentions; and perceived influences, susceptibility, and benefits of and barriers to health care. Recently, the transtheoretical model of change, or stages of change model, has been applied to sexual behaviors.[12] This model assesses each individual's current stage of making a behavioral change (precontemplation, contemplation, preparation, action, or maintenance) and provides stage-based interventions. While these models are still being tested for predictability, they do provide a practical framework for educational and service interventions of sexual risk behaviors. A group of seven demonstration projects (two clinic and five community projects) funded by the Centers for Disease Control and Prevention are currently applying the stages of change model to promote the use of condoms and other contraceptive methods, and to promote the use of reproductive health services among women at risk of HIV infection and transmission. In the two clinic projects, peer advocates deliver stage-based counseling services using a manual as a guide; in the five community projects, stage-based role model stories and other educational materials are geared to the individual's readiness to change behaviors.

"...race is a simplistic and ill-defined measure of a much more complex set of socially defined behaviors, beliefs, and customs."

The advantage of using multiple factors to assess sexual behaviors is that individuals are not forced into large, irrelevant categories such as a single racial group. Social scientists who collect data on a national level or from smaller samples should include multiple factors that are associated with behaviors being assessed in their surveys. Results can then be discussed in terms of groups that allow greater specificity for action steps. Important factors that are amenable to change through interventions yield useful information for sexual health educators, policy makers, and health professionals. With this information, they will be able to develop and to deliver more relevant information and programs for different target audiences.

The focus on racial groups in sexual health studies inhibits understanding of risky sexual behaviors. Using only race overlooks more relevant factors. Public health professionals need to rise to the challenge to identify alternative and useful descriptors and predictors of sexual behaviors, and to take the lead in informing

researchers, service providers, and educators. Through these efforts, they will make better progress at reducing behaviors that place individuals at risk.

Note: The opinions expressed in this article are those of the author, based on her years of experience in public health.

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SIECUS TO ADAPT PUBLICATIONS FOR HISPANIC/LATINO AUDIENCES

Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade

In 1991, SIECUS published the *Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade.* The *Guidelines,* developed by a national task force representing several mainstream education and health organizations, present a framework for developing new sexuality education programs or evaluating existing ones. They represent a model for a comprehensive program, delineating key concepts and their components, and developmentally appropriate messages for young people in kindergarten through twelfth grade.

The *Guidelines* were developed to be applicable to a wide range of communities, and the document stresses the diversity of cultural understandings of sexuality. Nevertheless, SIECUS recognizes that the *Guidelines* do not adequately address the specific needs of many cultural groups. In response to requests from professionals working in predominantly Hispanic/Latino communities, SIECUS has adapted and translated the *Guidelines* to serve those communities.

An advisory committee made up of education and health professionals from major national organizations serving Hispanic/Latino communities reviewed the *Guidelines* and developed a consensus regarding the developmental messages that need to be modified. The adaptation also includes lists of organizations and resources dealing with family life education that are culturally specific and culturally sensitive for use with Hispanic/Latino communities.

The new publication will contain both the English version and the Spanish adaptation *(Guia para una Educación Sexual Integral para la Juventud Hispano/Latina: De Kindergarten a Grado 12).* Expected publication date is March 1995; the price is $5.75. To order, contact the SIECUS Publications Department, 130 West 42nd Street, Suite 350, New York, NY 10036; 212-819-9770.

Talk about Sex

A great need exists for sexuality and HIV/AIDS education resources for Spanish-speaking young people—that is, resources that not only are in Spanish but are sensitive to the values and cultures of Hispanic/Latino communities in the United States. To meet this need, SIECUS is adapting and translating its 1992 publication *Talk about Sex: A Booklet for Young People on How to Talk about Sexuality and HIV/AIDS.* The booklet addresses communication and empowerment issues for young people, covering such topics as abstinence, setting limits, and safer sexual behaviors.

An advisory committee made up of members of each of the four primary Hispanic/Latino communities in the United States—Puerto Ricans, Mexicans, Cubans, and Central Americans—reviewed the English version of the booklet, have contributed ideas for the adaptation, and will review the adaptation and translation. The Spanish version of *Talk about Sex* will be pilot-tested in three communities. Expected publication date is March 1995.

BUILDING CULTURAL COMPETENCE:

Advocates for Youth's Guide to Working with Youth of Various Backgrounds

As rates of sexual activity, births, and sexually transmitted disease (including HIV) infection among teenagers increase, researchers and program leaders continue to search for effective strategies and materials that will reach young people with affirming messages about sexuality and with clear messages about the risks of sexual activity, particularly of unprotected sexual intercourse.

In addition, the increasing racial and cultural diversity of the United States and the growing recognition of gay, lesbian, and bisexual youth make it apparent that education strategies based on the experience and perspective of the majority European-American heterosexual culture often fail to engage youth of color and youth who are gay, lesbian, or bisexual.

Largely as a result of concern about African-American and Latino and Latina youth, much interest has centered on "culturally appropriate," "culturally relevant," or "culturally specific" approaches to prevention education. Debate continues about what constitutes such programs. Course content, instructor background and skills, teaching strategies, and location have all been discussed as critical factors; however, no clear conclusions have emerged from the limited research base.[1] There is a strong indication that youth of color benefit from staff who are caring and sensitive, as well as from adults who are racially and culturally similar to themselves, and that youth development programs should strive to hire staff who possess all these qualities.[2]

In the last few years, there has been an explosion of interest in addressing the needs of lesbian, gay, and bisexual teenagers. There are more than 200 support groups and agencies nationwide dedicated to this population, and several national groups, including the Child Welfare League and the National Education Association, have endorsed guidelines for working with these young people. Too often, however, the very existence of these youth is denied by program planners and leaders. As a result, young gay, lesbian, and bisexual people are not acknowledged, much less nurtured. In many cases, adults think—or even know—that some members of their groups are gay, lesbian, or bisexual, but lack information about and comfort with issues related to homosexuality. In other cases, leaders who themselves are gay, lesbian, or bisexual may feel profoundly torn between providing support to these young people and protecting their own privacy. Antigay prejudice (homophobia) and the persistence of the myth that homosexuals "recruit" young people create environments in which it is not safe for gay adults to reach out to young gay people. The result, in any case, is a continuation of the isolation and shame that many gay, lesbian, and bisexual teenagers feel.

The HIV/AIDS epidemic has highlighted the critical need for understanding cultural differences because HIV/AIDS prevention education demands frank discussion of sexuality—a sensitive subject in many communities and for many people. Understanding cultural beliefs about a range of sexual issues is critical to providing effective HIV/AIDS prevention education.

In *A Youth Leader's Guide to Building Cultural Competence,* Advocates for Youth presents a definition of cultural competence and an outline of important cultural components as the starting point from which professionals who work with youth can develop their own cultural competence and thus best serve youth from diverse backgrounds.

What Is Cultural Competence?

The term "cultural competence" has been used by a variety of people in recent years. It moves beyond the concepts of "cultural awareness" (knowledge about a particular group primarily gained through reading or studies) and "cultural sensitivity" (knowledge as well as some level of experience with a group other than one's own). Instead, cultural competence focuses on the fact that some level of skill development must occur. Being culturally competent is "more than being sensitive to ethnic differences, more than not being a bigot and more than the warm, fuzzy feeling of loving and caring for your neighbor."[3]

Gaining cultural competence is a long-term process of expanding horizons, thinking critically about issues of power and oppression, and acting appropriately. Culturally competent individuals have a mixture of beliefs and attitudes, knowledge, and skills that help them establish trust and communicate with others.

Beliefs and Attitudes. The culturally competent individual is aware of and sensitive to her or his own cultural heritage and respects and values different heritages; is aware of her or his own values and biases and how they may affect perception of other cultures; is comfortable with differences that exist between her or his culture and other cultures' values and beliefs; and is sensitive to circumstances that may require her or him

to seek assistance from a member of a different culture when interacting with another member of that culture.

Knowledge. The culturally competent individual must have a good understanding of how nondominant groups are treated in society; must acquire specific knowledge and information about the particular groups she or he is working with; and must be aware of barriers that prevent members of disadvantaged groups from using organizational and societal resources.

Skills. The culturally competent individual can generate a wide variety of verbal and nonverbal (body language) responses when dealing with difference; can send and receive both verbal and nonverbal messages accurately and appropriately; and can intervene appropriately and advocate on behalf of people from different cultures.[4]

Important Cultural Components

A useful definition of culture is: "the body of learned beliefs, traditions, principles, and guides for behavior that are commonly shared among members of a particular group."[5] Of course, many Americans belong to more than one cultural group. Lesbian, gay, and bisexual people almost always move within more than one cultural world. They are born into and raised as members of at least one racial or ethnic culture. In order to find others who share their sexual orientation, however, they commonly become part of larger gay and lesbian communities.

The journey toward cultural competence includes gaining knowledge about important components of one's own culture and the cultures one interacts with. The following list of cultural components is good to keep in mind, both in examining one's own experiences and beliefs, and in learning about different cultural backgrounds. Many of these components have direct bearing on HIV/AIDS prevention efforts.

Language and Communication Style. This component refers to a wide variety of verbal and nonverbal patterns and behaviors, including social customs about who speaks to whom—both how and when. Questions to consider about cultural groups include what language or dialect is spoken in the home, what body language commonly accompanies communication, whether all family members have the same right to speak, and whether emotions are freely expressed.

Health Beliefs. While the "germ theory" of disease is the belief of the dominant culture of the United States, it is not the only explanation people have for disease. Some people believe that the mind can affect the body's health in surprising ways. Others believe in "supernatural" theories of disease, including that a particular disease results from spiritually unhealthy activity.

Likewise, while many who live in the United States turn for medical care to a doctor or another professional trained in the "Western medical model," others seek out practitioners of "alternative health care"—healers such as spiritualists, herbalists, acupuncturists, or homeopaths.

Questions to consider about cultural groups include what assumptions they make about the causes and prevention of disease, and whom they turn to when sick.

Family Relationships. This topic includes family structure, roles, dynamics, and expectations. Questions to consider about cultural groups include the rights and responsibilities of family members, and whether rights and responsibilities vary by gender or age; who has authority in the home; whether openly gay, lesbian, or bisexual family members are accepted; whether same-gender life partners of gay or lesbian relatives are considered family members; the impact of marriage outside the cultural group; and how privacy is treated within the home.

Sexuality. Sexuality includes five major areas: sensuality, sexual intimacy, sexual identity, reproduction and sexual health, and sexualization. Questions to consider about cultural groups include how intimacy is expressed; how people of the same gender express feelings of closeness to each other; whether certain sexual acts are taboo; how masturbation is viewed; whether dating is allowed; how homosexuality is viewed; and whether gay, lesbian, and bisexual people are accepted and respected in the community.

Gender Roles. There has been tremendous change in the United States in the last twenty years with regard to what is considered appropriate and acceptable behavior for men and women. There are, however, still many deeply held beliefs about which behaviors are feminine and which are masculine. Questions to consider about cultural groups include whether tasks within the home are assigned by gender, whether both genders are expected to express emotions freely, and whether there are different expectations about sexual behavior for boys and girls.

Religion. Many, if not all, religions establish sexual norms. Most organized religions condemn homosexuality, and so it is often difficult for gay, lesbian, and bisexual people to find full acceptance and spiritual peace within their families' house of worship or religious tradition. Questions to consider about cultural groups include what religion the group generally adheres to, what that religion teaches about gender roles and homosexuality, how young people express their religious beliefs, and whether certain behaviors are taboo.

Level of Acculturation. Acculturation occurs when two cultural groups come in contact with each other and change occurs in at least one of the two. Individuals

within racial or ethnic groups may fall anywhere along a continuum in terms of level of acculturation, from having given up most of the traits of the culture of origin and assumed those of the dominant culture to having little contact with traits of either culture.[6] Questions to consider about individuals include their degree of acculturation; what cultural values, beliefs, attitudes, traditions, and behaviors they have retained; and what traits of the dominant culture they have absorbed.

Immigration Status. Designation as a "refugee" can mean a period of cash assistance and, with employment, housing and medical services from the government.[7] The designation "immigrant" can open access to government assistance with medical, educational, or food programs.[8] No government services are available for those who are "undocumented," and finding employment is very difficult for these individuals because employers face severe fines for hiring them.[9] Questions to consider about individuals include their immigration status, whether they live in a community with people from different racial and ethnic groups, and how these groups get along.

Political Power. Groups with political power—that is, with formal involvement in various levels of government, as well as in advocacy organizations—are able to influence public policy decisions, often to the benefit of their interests. Groups that are left out of the political process have no guarantee that they will be well served by the process. Questions to consider about cultural groups include how well represented they are in various levels of government, what advocacy organizations work on their behalf, and who their formal and informal leaders at the national and local levels are.

Racism. Racism is the addition of some form of power to racial prejudice. The mechanisms that tend to keep people of color out of jobs, out of school, in poor health, and in certain neighborhoods include a complex mix of economic issues, political decisions, and individual acts. Questions to consider about cultural groups include the impact of racism on the group, how individuals are affected by racist attitudes and practices, the impact of racism on children and teenagers, and how the informal and formal leaders of the group address racism.

Poverty and Economic Concerns. There is poverty in all cultural groups, and no one cultural group has only poor people in it. Therefore, questions about poverty and economic concerns should be focused on a specific community or group of individuals, not on an entire racial or ethnic group. Questions to consider about cultural groups include levels of employment among adults, what kinds of jobs individuals hold, and whether they receive benefits; how hard it is for teenagers to get jobs; how many people are on public assistance, and the impact of public assistance on family formation; the health problems in the community, how many doctors or clinics are available, and whether most people are covered by health insurance.

History of Oppression. The history of the United States includes many chapters in which government policies harmful to racial and ethnic groups were in force. Today, laws and policies are different, but many are still oppressive. For example, in some states, there is a move toward English-only legislation that would restrict state agencies from providing bilingual services; civil rights protections for gay and lesbian people are being attacked through ballot measures labeling those protections "special rights." Questions to consider about cultural groups include what laws or policies have affected them in the past, what laws and policies affect them today, and the impact of these laws and policies.

Meeting the Challenge of Diversity

Working with teenagers and families whose backgrounds are different from one's own is one of the most difficult challenges of sexuality education in general, and of HIV/AIDS education in particular. Building cultural competence is a must for professionals in these areas. It is a long and complex process, but the reward is the ability to work effectively and respectfully with young people from a variety of backgrounds.

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BACK TO THE FUTURE:

The Past and Coming Congressional Battles over Sexuality Issues

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Throughout the Democratic-led 103d Congress, advocates for thoughtful policies on sexuality-related matters were engaged in debates on a diverse array of federal initiatives. The results were mixed; the major victories were that extremist approaches to sexuality issues were avoided—at least for the time being. As a result of the 1994 elections, the 104th Congress will be Republican-controlled and certainly more conservative, particularly on sexuality issues. Advocates need to be alert to the likelihood that the new Congress will aggressively revisit the issues at the heart of these debates.

AFLA: Abstinence-only Survives in Name Only

The Adolescent Family Life Act (AFLA), the controversial abstinence-only promotion effort better known as the "Chastity Act," was nearly ended in 1994. The president's budget for fiscal year 1995 did not set aside funding for the program; instead, it appropriated funds for the Office of Adolescent Health within the Department of Health and Human Services. Lack of funding for the AFLA program would have meant its discontinuation.

While AFLA does provide worthwhile services for teenagers who are pregnant or parents, and provides funds for valuable research on teenage pregnancy and parenthood, its education programs have often relied on a fear-based approach. During the 1980s and the early 1990s, the program was administered in such a way as to support organizations opposed to comprehensive sexuality education by providing funds for efforts like *Sex Respect*.

After considerable pressure from conservative members of Congress, AFLA received a $6.7 million appropriation. Other funds will have to be found for the Office of Adolescent Health. In the meantime, the Office of Population Affairs has made a concerted effort to fund prevention efforts that take a more comprehensive approach, and further changes in the administration of the AFLA program may occur with the arrival of Felicia Stewart, the obstetrician-gynecologist who became deputy assistant secretary for population affairs in November 1994.

Health Care Reform: Futile Modifications

Even though health care reform was a top priority of the Clinton administration, the 103d Congress passed no new legislation in this area. In January 1993, First Lady Hillary Rodham Clinton and Ira Magaziner, senior advisor to the president from the Office of Domestic Policy, were chosen to head the National Health Care Reform Task Force, a 500-person body composed mostly of Capitol Hill staff, medical professionals, and academics, as well as six cabinet secretaries. After a series of much-publicized town meetings to hear the public's needs for health care reform and much questioning of the task force's working style, President Clinton presented his 1,342-page Health Security Act.

Once the legislation was presented, it went to five congressional committees for consideration. With its detailed recommendations for change, the Health Security Act was vulnerable to an onslaught of criticism and disagreement both inside Congress and out. Many members of Congress developed counterproposals. The full schedule of hearings on the legislation that dominated the work of the congressional committees through June 1994 revealed that each committee would be creating its own form of the bill, and that a huge array of issues were in contention. Attacks by the health insurance industry, lack of agreement in Congress, falling presidential approval ratings, and the complexity of the Clinton plan led to diminishing public support for the president's health care reform effort.

By August 1994, the Clinton plan was proclaimed unworkable. Rep. Richard Gephardt (D.-MO) led the House Democratic effort with his version of health care reform. Retiring Senate Majority Leader George Mitchell (D.-ME) introduced his proposal—a meld of the Education and Labor Committee's, the Finance Committee's, and the president's plans—for the Senate to debate. Senator Mitchell threatened to hold a

nonstop session on health care reform unless Republican senators allowed a vote, but the disagreement between the political parties and between factions of Democrats made passage of any bill impossible. Even stark, scaled-down insurance reform proposals proved politically unacceptable. Congress adjourned on August 25 without a vote, signaling the end of health care reform efforts for the 103d Congress. On September 26, two weeks after Congress reconvened, it formally abandoned health care reform.

In the months afterward, the Clinton administration suggested that its own approach to health care reform for the 104th Congress would be different—and considerably lower-key. This sea change formally occurred when the high-profile heads of the National Health Care Reform Task Force, Hillary Rodham Clinton and Ira Magaziner, stepped down. Moreover, many of the 1994 postelection analyses indicate that health care reform is a major factor in the voting public's disapproval of President Clinton and, by extension, of Democratic incumbents.

All eyes will be on two committees for indications of how health care reform will be handled by the 104th Congress: the Senate Labor and Human Resources Committee, to be led by Sen. Nancy Kassebaum (R.-KS); and the House Commerce Committee (formerly the Energy and Commerce Committee), to be headed by Rep. Thomas Bliley (R.-VA). Efforts will likely focus on modest health insurance industry reforms. To the dismay of youth advocates, proposals such as the school health centers and school health education components of the Clinton plan and the Senate Education and Labor Committee plan could be noticeably different in the next congressional session.

Moderate Welfare Reform: Trouble Ahead

The attempt to "end welfare as we know it" fell far short of the mark in the 103d Congress. In large part because the Clinton administration placed a higher priority on health care reform—stating that health care reform itself is a welfare reform measure—serious consideration of welfare reform did not begin until late spring of 1994.

The administration's welfare reform legislation, introduced in Congress in June, contained several controversial elements and reflected the reported intent of the administration to "talk tough." A proposed two-year limit on virtually all benefits, "family caps"—state options to refuse additional benefits for children born to families on Aid to Families with Dependent Children (AFDC)—and a requirement that teenage mothers live with their parents raised serious concern among many women's and social service advocates.

The plan also included a teenage pregnancy prevention effort—a national media campaign against teenage pregnancy; a $200 million grant program for school-linked teenage pregnancy prevention programs (with no requirement for reproductive health services) in high-risk areas; $20 million for five demonstration programs for comprehensive service programs that include "health education and access services" (which may include family planning) to address teenage pregnancy; and a national clearinghouse to collect and disseminate information about successful teenage pregnancy prevention programs. Although this plan is heartening in that it is the largest teenage pregnancy prevention effort proposed in recent years, the lack of emphasis on contraceptive services is disappointing.

The Senate Finance Committee, the House Committee on Ways and Means, and the latter's Subcommittee on Human Resources have held welfare reform hearings, some of which focused on teenage pregnancy. Otherwise, action on welfare reform nearly came to a halt when the Congress struggled at the end of the session with health care reform. The more conservative and "accountability-minded" 104th Congress is likely to engage in a heated debate on welfare reform, focusing on stigmatizing the behaviors of low-income individuals. The Republican-backed "Contract with America" proposes a highly punitive approach, denying *all* benefits to unmarried teenage mothers. It is entirely possible that welfare reform will follow the path of health care reform—becoming less comprehensive and less constructive while the tone of the debate becomes more hostile.

ESEA: The Debate over Sexuality Education

The Elementary and Secondary Education Act (ESEA), a $12 billion education funding bill, was the hot spot for activists on sexuality-related issues in the 103d Congress. In March 1994, the House debate on the bill produced amendments on gay and lesbian youth services and sexuality education. Rep. Mel Hancock (R.-MO) attempted to prohibit funds to be used for programs that "promote" homosexuality as a "positive lifestyle," and Rep. Jon Doolittle (R.-CA) tried to set content requirements for sexuality education—despite two laws prohibiting federal intervention in local curricula decisions. Modification added by Rep. Jolene Unsoeld (D.-WA) that underscored local control over education programs rendered both amendments harmless.

However, when the Senate considered ESEA in August, Sen. Bob Smith (R.-NH) joined forces with Sen. Jesse Helms (R.-NC) to offer an amendment similar to Representative Hancock's; the Smith-Helms language was adopted by a vote of 63–36. Furthermore, a modifying amendment offered by Sen. Edward Kennedy (D.-MA) prohibiting the use of ESEA funds for programs that are designed to promote sexual activity, either heterosexual or homosexual, was adopted by a vote of 91–9. (The amendment was intended to be a negotiating tool for the conference on ESEA, in which members of the House and Senate would work out differences in their versions of the legislation.) A Kennedy amendment

prohibiting the use of ESEA funds for condom availability programs won unanimous approval. (ESEA funds could not be used for this purpose anyway.)

The conference on ESEA proved contentious. The amendments dealing with homosexuality and sexuality education were eventually merged into one "sex issues" amendment on sexuality and HIV education. The final language prohibits the use of ESEA funds for programs designed to encourage sexual activity; for the distribution of legally obscene materials; for sexuality and HIV education programs that are not age-appropriate or do not present the health benefits of abstinence; and for condom availability programs. The language provides some comfort for sexuality and HIV education supporters because sexuality education does not involve these activities. Moreover, the final language also stipulates that the federal government will not use its authority to enforce these provisions.

However, local sexuality education opponents may find an excuse for renewing attacks on programs. They may imply that Congress has issued new prohibitions and that existing programs should be reconsidered in response to the new pronouncements. Proponents of sexuality education should be aware that comprehensive sexuality education programs need not be revisited because of this legislation, and should be prepared to defend quality programs against the unfounded implication of the new prohibitions—that programs may be engaging in inappropriate activities. Even though ESEA is now law, the debate could be reopened in the 104th Congress, because a bill correcting important technical errors in the printing of the legislation will be considered—providing new opportunities to attack sexuality education.

Clues to the 104th Congress

The 1994 elections placed control of the Congress firmly in the grasp of a Republican majority. The Democrats suffered the worst midterm losses in thirty-six years—meeting with defeat in sixty Senate and House races. Whereas the previous Senate held fifty-six Democrats and forty-four Republicans, the new Senate will have forty-seven Democrats and fifty-three Republicans. Likewise, Republicans made significant gains in the House—the previous House had 256 Democrats, 178 Republicans, and one Independent; the new House will have 204 Democrats, 230 Republicans, and one Independent.

Republican control of the House and Senate means more than just a voting majority for Republicans. It also means that leadership of legislative committees changes political parties. Of note to advocates of comprehensive sexuality education, the chair shifts from a Democrat to a Republican in the Senate Education and Labor Committee, the Senate Finance Committee, the House Commerce Committee, the House Economic Opportunity Committee (formerly the House Education and Labor Committee), and the House Judiciary Committee. Moreover, Republicans have pledged to eliminate a host of committees, realign committee jurisdictions, and dramatically cut congressional staff—especially committee staff. Overall, an estimated 1,500 congressional staff will lose their jobs as a result of the elections and congressional restructuring.

Several legislative proposals and priorities for the Republican-led Congress have also materialized. The "Personal Responsibility Act," part of the Contract with America, would require states to deny aid to the children of young, unwed mothers and to children whose parents are AFDC recipients. It also would make individuals who reach the federally mandated time limit permanently ineligible for AFDC; this would apply to children, individuals who cannot find a job or are unemployable, and people with disabilities. These restrictions are especially harsh given that nowhere in the welfare proposal is there a provision for education to assist participants in maintaining sexual health or avoiding unwanted pregnancy. Another component of the Contract with America is a reinstatement of the Title X "gag rule." Finally, despite the statement of newly appointed House Speaker Newt Gingrich (R.-GA) that the Republican party's stance on homosexuality should be "toleration" (meaning neither promotion nor condemnation), Representative Hancock has vowed to reintroduce his effort from the ESEA debate to cut off federal funds to schools that "teach homosexuality is a positive lifestyle alternative."

Advocates of sexual rights and sexual health will have to work hard and have to work smart in order to avert the passage of regressive public policy that threatens to deny individuals much-needed information about, funding for, and accessibility to basic sexuality education, public assistance, and sexual health services. If you are not a member of the SIECUS Advocates Network, there has never been a more critical time to join. Advocates receive the quarterly *Advocates Report* and time-sensitive action alerts. Please send your name and contact information to: SIECUS Advocates; Betsy Wacker, Director, Public Policy; 130 West 42nd Street, Suite 350; New York, NY 10036. Channel your energy and conviction into meaningful activism.

RESPONDING TO "THE FAILURE OF SEX EDUCATION"

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In the cover story of the October Atlantic Monthly, *"The Failure of Sex Education," Barbara Dafoe Whitehead describes comprehensive sexuality education as a failed experiment that has contributed to the rising incidence of teenage pregnancy and sexually transmitted diseases among adolescents. The author asserts that sexuality education is "based on no known field of knowledge," and she implies that sexuality education courses routinely discuss sexual behaviors in an explicit manner. Unfortunately, this article has received a great deal of attention. Proponents of comprehensive sexuality education are struggling to respond effectively to Dafoe Whitehead's charges. SIECUS hopes the following critique will be useful in responding to the article.*

Barbara Dafoe Whitehead is not simply a journalist. She is the vice president of the Institute for American Values, a conservative think tank that deals with issues related to families. Most of her writing has revolved around the "decline of the traditional nuclear family." Her best-known work before this article was "Dan Quayle Was Right," the *Atlantic* cover story in April 1993.

Clearly, a strong ideological bias influences Dafoe Whitehead's writing and research, and the author's perspective on the "proper" types of messages for young people framed her investigation of sexuality education. Dafoe Whitehead overlooked many facts in pursuing her argument that comprehensive sexuality education has damaged young people. Furthermore, she used SIECUS material for her article, but did not quote from publications of any organizations that support comprehensive sexuality education.

The following facts might be helpful in responding to her arguments.

- Dafoe Whitehead assumes that comprehensive sexuality education has been taught for years throughout the country. In fact, fewer than 5 percent of young people receive any instruction related to family life and sexuality education in every year of school; fewer than one-quarter receive such instruction in elementary, junior high, and senior high school.[1]

- The cover of the *Atlantic* mentions the rise in teenage pregnancy rates. In fact, among sexually active teenagers, the rate has dropped 19 percent in the past two decades. It is true that among all teenagers, the rate has gone up. However, the proportion of adolescents having intercourse rose dramatically in the 1970s.[2] Without information about and access to contraception, teenagers would undoubtedly have much higher pregnancy rates.

- Despite being portrayed as a new expert on sexuality education, Dafoe Whitehead does not seem familiar with any sexuality education curricula other than *Learning about Family Life,* which she criticizes at length. She writes that: "Unlike standard sex-education curricula, which are about as exciting to read as an IRS Form 1040, *Learning about Family Life* tells a story." Most sexuality education curricula developed in the last decade—even abstinence-only, fear-based approaches—strive to engage young people in the material by presenting them with interesting stories, scenarios, and exercises.

- According to Dafoe Whitehead, researcher Douglas Kirby has concluded that sexuality education programs do not alter behavior. In fact, Kirby's recent work has shown that some sexuality education programs help young people to postpone intercourse and to use contraception when they are sexually active. Kirby responded to the *Atlantic* piece in a letter to the editor. Unfortunately, the *Atlantic* chose not to run Kirby's letter, but the complete text appears here, in the box on page 19.

- Dafoe Whitehead implies that New Jersey's comprehensive family life education has had no effect, and that the birthrate among New Jersey teenagers has increased. In fact, the birthrate declined steadily between 1989 and 1992, from 43 per 1,000 teenagers to just under 40 per 1,000.[3]

- In Dafoe Whitehead's interpretation, *Postponing*

Sexual Involvement is an example of an abstinence-based program that has been proven effective. However, she fails to point out that the evaluations have taken place in settings where *Postponing Sexual Involvement* is used in conjunction with components addressing sexuality and contraception. In such cases, the program has indeed been effective in helping young people to delay first intercourse.[4]

- Dafoe Whitehead suggests that there is a sexual latency period for children between the ages of six and twelve. According to researchers from the American Psychological Association,[5] no such latency period exists. Furthermore, they point out that opponents of comprehensive sexuality education often use "selective and inaccurate presentation" of psychological theories of child and adolescent development—including Freud's latency theory—to explain the "alleged ill-effects" of such education.[6] But, they note, Freud himself "did not believe that sex education was harmful for pre-pubescent adolescents."[7] Summarizing their findings, the researchers state that "most of what is known indicates...that children and adolescents are capable of reaching reasonable and valid decisions regarding complicated topics. Accurate and comprehensive information would thus seem to be a minimum necessity for ensuring that they make the most healthful decision."[8]

- Although Dafoe Whitehead does not explicitly recommend abstinence-only, fear-based programs as the answer to teenage sexual activity, she does accept as fact many of the assumptions underlying those programs and repeats the misinformation and stereotypes they present. For example, reflecting a gender stereotype that undergirds the fear-based curriculum *Sex Respect,* she states that "girls use sex in order to get love, and boys give love in order to get sex."

- Dafoe Whitehead writes that whereas young men once were "craven sexual petitioners" thwarted by young women's sexual refusals, young women today have "lost much of their authority in boy-girl relationships" because of the sexual revolution. The only evidence she gives for her assertions about gender difference is that when she asked her college-age daughter if there were differences in the ways men and women on campus conducted their sex lives, her daughter replied: "Only that girls wait for a phone call the next day." Notably, one of Dafoe Whitehead's major criticisms of *Learning about Family Life* is that the curriculum attempts to help young boys communicate and feel comfortable with their feelings, and help girls ask their questions related to sexual behavior.

- Seventeen members of the National Coalition to Support Sexuality Education have signed a statement that will be sent to the *Atlantic* and made available as needed declaring that "The Failure of Sex Education" presented "opinions and inaccuracies that may have misled the reader as to the actual content, value and status of comprehensive sexuality education in the United States."[9]

Supporters of comprehensive sexuality education can help stop the promulgation of misinformation from the *Atlantic* article by taking the following actions:

- Monitor local papers for editorials and articles reiterating Dafoe Whitehead's arguments. Write letters to the editor or submit op-ed pieces discussing the shortcomings of the article and the need for comprehensive sexuality education.

- Send SIECUS copies of articles from local newspapers so that we may consider responding directly to attacks on comprehensive sexuality education.

- Develop talking points to send to organizations, local school boards, teachers, and school administrators who are trying to support comprehensive sexuality education.

- Contact SIECUS for further technical assistance.

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2. The Alan Guttmacher Institute, *Sex and America's Teenagers* (New York, 1994): 41.

3. Association for Children of New Jersey, *Kids Count: New Jersey 1994: State and County Profiles of Child Well-being* (Newark, NJ: 1994).

4. D. Kirby, *School-based Programs to Reduce Sexual Risk-taking Behaviors: Sexuality and HIV/AIDS Education, Health Clinics and Condom Availability Programs* (Santa Cruz, CA: ETR Associates, 1994).

5. C. Bartels, S. Limber, and B. Wilcox, "The Improper Use of Developmental Theory and Research to Support Abstinence-only Sex Education Curricula" (Washington, DC: American Psychological Association, 1994).

6. Ibid., p. 1.

7. Ibid., p. 4.

8. Ibid., p. 13.

9. These organizations are Advocates for Youth, AIDS Action Council, American Orthopsychiatric Association, American School Health Association, National Abortion Federation, National Asian Women's Health Organization, National Center for Health Education, National Council of Churches, National Council on Family Relations, National Education Association Health Information Network, National Lesbian and Gay Health Association, Planned Parenthood Federation of America, SIECUS, Unitarian Universalist Association, United Church Board for Homeland Ministries, University of Pennsylvania Graduate School of Education, and Zero Population Growth, Inc.

DOUGLAS KIRBY RESPONDS TO THE *ATLANTIC*

Douglas Kirby, director of research at ETR Associates, whose work is repeatedly cited in Barbara Dafoe Whitehead's article, sent the following letter to the editor of The Atlantic Monthly *in response to that article. The* Atlantic *declined to publish the letter; we run it here to help clarify some of the points Dafoe Whitehead makes, and to present a more balanced view of research findings on sexuality education.*

In her critique of comprehensive sex education, Barbara Dafoe Whitehead raises some important concerns that all of us involved in sex education should thoughtfully consider. However, I am concerned that while Whitehead's article appears to be reasonable and balanced on the surface, it is actually misleading in several respects.

Perhaps most important is that she directly states and leaves the reader with the clear impression that sex education has failed. This, at best, is an imbalanced view. She correctly and repeatedly quotes my conclusions about what kinds of sex education programs have not had a desirable and measurable impact upon adolescent sexual behavior, but she gives less attention to my conclusions about what kinds of sex education programs *do* have a desirable and measurable impact upon behavior. Furthermore, she gives relatively little attention to the programs which have been demonstrated to change sexual *and* contraceptive behaviors. More generally, she gives little weight to the growing body of research that demonstrates that sex education programs do make a difference.

A review supported by the Centers for Disease Control and Prevention of all published research on sex education programs concluded that (1) sex education programs currently implemented throughout the country do not hasten the onset of intercourse or increase its frequency, (2) as a whole, these programs modestly increase the use of contraception, and (3) some specific programs have a larger, more programmatically important impact upon behaviors than others.

Currently, there exist at least six studies of specific sex education or HIV education programs that demonstrate that these curricula improve adolescent sexual and contraceptive behavior. These programs delay the onset of sexual intercourse, reduce the number of sexual partners, increase the use of contraception, and/or reduce the frequency of intercourse without contraception. Some of these programs reduce unprotected sex by 40 percent or more. For a variety of statistical reasons that are beyond the scope of this letter, it is very difficult to measure the impact of any program upon adolescent pregnancy, birth or STD rates. Nevertheless, it is certainly logical to conclude that if sex and HIV education programs have these desirable effects upon behavior, they will also reduce adolescent pregnancy, birth and STD rates.

The programs that do effectively change behavior have the following characteristics: They focus upon changing specific sexual behaviors. They are based upon established theories of behavior change proven to be effective in other risk-taking areas (e.g., substance abuse). They provide accurate information in a manner that causes students to personalize and retain that information, instead of quickly forgetting it. For example, they use many interactive activities rather than didactic lectures. They address social pressures to have sex (e.g., lines used to get someone to have sex, and rejoinders to those lines). They model ways to say no to sex (or to unprotected sex) and provide practice in those skills. Perhaps most important, they provide a clear message that is both age- and experience-appropriate. For younger sexually inexperienced youth, an effective message is: Wait until you are older to have sexual intercourse. For somewhat older youth, some of whom are beginning to have sex, an effective message can be: Avoid unprotected intercourse—the best way to do this is abstinence; if you have sex, always use protection. For high-risk youth, most of whom are having intercourse, an effective message is: Always use condoms; otherwise you may get AIDS.

Given the innumerable factors affecting adolescent sexual behavior (e.g., hormones, needs for love and affection, family values, peer norms and pressures, the media, and other societal pressures), no one should expect there to be any magic solutions to the problems of adolescent sexual behavior. This is not realistic. And, in particular, sex education curricula lasting only five to ten hours—as most of them do—cannot be expected to have a dramatic impact upon adolescent sex. However, curricula with the characteristics described above can have some impact upon behavior and should be a component in any larger, more comprehensive program to address these important issues. Implementing these effective programs with fidelity across the country is our current challenge. Unfairly attacking them, diluting them or terminating them is a retreat.

A REPORT FROM CAIRO

James Shortridge, M.A.
Director, International Programs, SIECUS

The International Conference on Population and Development (ICPD) and parallel Non-governmental Organization (NGO) Forum in Cairo in September 1994 provided an unprecedented opportunity for SIECUS, as an official accredited organization at the NGO Forum, to assess the level of awareness and knowledge of sexuality issues among international population, health, environment, and government institutions. It also gave us an opportunity to evaluate the direction of our international initiative, and support sexual and reproductive rights.

The ICPD Programme of Action

As readers of the *SIECUS Report* are undoubtedly aware, the ICPD negotiations on the draft Programme of Action brought much controversy around issues related to sexual and reproductive health. In the draft presented to the conference, the majority of the references to "sexual health" were in the chapter entitled "Reproductive Rights and Reproductive Health" (chapter 7). That chapter was addressed early in the meeting, in hopes of settling the most controversial issues quickly. Discussions about chapter 7 were lengthy and heated; it soon became clear how differently "sexuality" was defined among country participants. At the NGO Forum, several standing-room-only sessions addressing sexual health were conducted by organizations representing a variety of countries and cultural viewpoints. SIECUS conducted one such presentation, on comprehensive sexuality education and its relationship to reproductive health, and was active in both the Youth Caucus and the Women's Caucus, where sexuality was a recurring theme. Unfortunately, the goal of completing the work on chapter 7 early in the conference unraveled over the paragraph pertaining to abortion; it was only after a full week of negotiations over rewording of the definition of family planning that discussion moved on to other issues.

At the final session, after much debate and compromising, all delegations, including the Holy See, adopted the sixteen-chapter Programme of Action, creating an unprecedented consensus of over 180 nations. The final document represents a major advance in its broad view of population policy and emphasis on the reproductive rights and health of individuals, and offers a comprehensive strategy to address population and development issues over the next twenty years.

The Programme of Action calls for a shift from a focus on demography and population control, to an emphasis on sustainable development and the recognition of the need for comprehensive reproductive health care and reproductive rights. The document includes strong language on empowering women and providing them with more choices by expanding access to education and health services and promoting skill development and employment; a reaffirmation of the central role of the family; respect for different values and religious beliefs; the urgency of combating HIV/AIDS; and protecting the health of adolescents. It recognizes the importance of family planning, but also sees social investments in health and education as key to creating a favorable climate for voluntary measures aimed at fertility decline. The document emphasizes that family planning programs should respond to the needs of individuals, and includes new concepts and strong language on the need for sexuality education and contraceptive services for adolescents. While some delegations disagreed that adolescents should have access to reproductive health care, including family planning, the fact that an entire section of chapter 7 is dedicated to the needs of adolescents is indicative of how important participants considered the issue. The final text acknowledges the need "to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, sexually transmitted disease and HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group." Though the term "sexual health" eventually was integrated into "reproductive health," never before had such a wide body of delegates so openly addressed some of these sexuality issues.

In several aspects, the ICPD's process and outcomes were unique. The ICPD was the first United Nations conference to endorse "reproductive rights"—and it did so despite vigorous opposition from certain religious coalitions. Also, the concept of reproductive health put forward in the Programme of Action represents a change in thinking about fertility—considering it a reproductive health issue rather than strictly a development goal.

Although the Programme of Action articulates a shift toward a broader reproductive health approach, the financial commitments to making these services available do not even come close to matching those

that had previously gone to family planning programs. A number of donor countries have committed significant increases in funding to population and family planning initiatives. The United States Agency for International Development has committed itself to incorporate a greater emphasis on reproductive health within its existing programs, and to improve the integration of family planning and reproductive health activities where appropriate. Some of this reorganization is designed to facilitate exploration of how to address adolescent sexual health issues. The challenge lies in the specifics of implementing the program at an operational level, particularly where resources are scarce and health delivery systems are weak. Existing programs will have to enhance coordination of their services; countries will have to make significant funds available to make such coordination possible, as organizations will increasingly compete for scarce resources.

The SIECUS International Initiative

While many agree that the Cairo conference represented considerable progress, the challenge now is to ensure that the Programme of Action is translated from words into action. SIECUS believes that appropriate responses to world population growth must acknowledge the interactions among social, cultural, economic, and environmental conditions.

Sexuality education and health services are an integral component of efforts to improve reproductive health care. In the United States, SIECUS is the only national organization with a primary emphasis on sexuality education. In the fall of 1992, SIECUS began planning a new international initiative. A review of the libraries of seventeen population-related organizations revealed that none have a significant collection on sexuality or sexuality education. In addition, none of the international organizations concerned with family planning and population issues have a major program focus

THE ICPD ON REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

The following are key paragraphs from chapter 7 of the ICPD Programme of Action, dealing with reproductive health and reproductive rights.

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right of all to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

on sexuality. The traditional participants in the population and family planning field have tended to shy away from the touchy questions involving sexuality. Beyond some efforts aimed at adolescents, no forum exists for the international exchange of successful program models, research, and curricula in sexuality education. No guidelines for integrating sexuality education into family planning service delivery or school-based programs are available. The HIV/AIDS pandemic has highlighted the absence of thoughtful initiatives on sexuality and sexuality education as a glaring deficiency in the field.

Therefore, in 1993, SIECUS added an international component to our sexuality information and education clearinghouse. In the first year of our international initiative, SIECUS provided assistance to over 250 professionals in more than thirty countries. Our ability to offer such assistance relies on our extensive collection of sexuality and HIV/AIDS education curricula, international research studies and reports, sexuality training models, conference and meeting proceedings, country policies, and program assessments. In the coming year, SIECUS will develop material to meet gaps in information, create a forum on the Internet to enhance communication efforts of professionals from other countries, and disseminate information to educators and service providers outside the United States.

"...the challenge now is to ensure that the Programme of Action is translated from words into action."

In 1991, SIECUS published the *Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade,* a model to promote and facilitate the development of comprehensive sexuality education programs and to improve existing programs. While specific to the United States, the publication has received significant interest in other countries. In 1993, SIECUS conducted a pilot project with three sexuality and HIV/AIDS organizations in Brazil, assisting them to adapt and translate the *Guidelines* for Brazilian schools. Brazil's Ministry of Education has purchased the *Guia de Orientação Sexual: Diretrizes e Metodologia* for distribution to teachers throughout the country. SIECUS has been asked to replicate this project in other countries, and is exploring the feasibility of doing so in Russia, China, and India.

It is clear that many country directors, program officers, and individuals responsible for delivering family planning and reproductive health services are uncomfortable with sexuality issues. SIECUS is working with international population and family planning programs to integrate sexual health into reproductive health programs and build a consensus about what, in fact, is a sexually healthy adult.

As SIECUS continues to work with other countries, we will explore additional gaps in information and services. For example, SIECUS staff are implementing a pilot training workshop for educators in Nigeria to address school-based sexuality education programs, and will assist professionals in developing the knowledge, skills, and comfort they need to effectively provide quality sexuality education programs.

The ICPD document is an important beginning toward changing the dialogue concerning sexual health. Successful implementation of the Programme of Action will depend upon the steps taken by governments and NGOs in the years to come. NGOs must devise strategies to hold governments accountable and to develop collaboration efforts to assist them in actualizing the many goals articulated in the Programme of Action. The upcoming World Summit for Social Development in Copenhagen and the Fourth World Conference on Women in Beijing will provide important opportunities to continue this dialogue and to promote local, national, regional, and international participation in the implementation of the Programme of Action. SIECUS needs members' help and participation in determining ways in which we can contribute to these efforts. Write to us with your suggestions.

SIECUS HAS MOVED

SIECUS has moved into larger, improved facilities in the same building we have been in since 1990. Our new space features 8,000 square feet of offices, including a custom-designed library that is triple the size of our former one. We are confident that this move will provide us with a stronger foundation than ever to provide our services to millions of Americans.

Our new address is 130 West 42nd Street, *Suite 350,* New York, NY 10036. Our phone and fax numbers remain the same: 212-819-9770 (phone) and 212-819-9776 (fax).

• BOOKS & VIDEOS • BOOKS & VIDEOS •

AM I BLUE? COMING OUT FROM THE SILENCE
Marion Dane Bauer, Editor
New York: HarperCollins, 1994, 274 pp., $15.00

The sixteen original stories for young readers in *Am I Blue?* describe the experiences of gay and lesbian teenagers as they come out from the silence. Some of the stories are biographical; some pure fiction. The editor, Marion Dane Bauer, may give the best description when she writes of her own contribution: "The story is entirely true and mostly made up."

Bauer's intent is for the book "to tell challenging, honest, affecting stories that will open a window for all who seek to understand themselves or others." Her dream is for gay and lesbian characters to be as integrated into fiction as they are into life. (The first novel for young readers featuring gay issues was John Donovan's *I'll Get There, It Better Be Worth the Trip,* published in 1969; since then, some sixty books for youngsters have included gay and lesbian themes, but none have featured gay men or lesbians as major characters.)

The authors of these stories, accomplished writers of juvenile and young adult literature, are male and female, gay and straight, married and living with partners. They are parents from different cultural and ethnic backgrounds. Some have children with a disability; some, children who are mixed race; some, children who are gay or lesbian. A biographical sketch of the author follows each story, and these are interesting and revealing. One author, for instance, speaks of her cowardice in facing her daughter's lesbianism, and recognizes the strength her daughter has shown in establishing her own life.

The stories tell of self-recognition, of coming out to families and friends, of young people grappling with their sexual identity. In a story about two roommates at a parochial school whose close relationship opens their minds to the possibility of one woman's loving another—and leads to their being wrongly accused of having sexual relations—one girl says, "Sometimes in my life I have been sure I knew something when really I didn't have a clue...but this time was not one of those times. I was perfectly clear about the fact that I was confused." Ultimately, the stories are affirming. For example, in one, a young woman who has been thrown out by her parents tells how hard it has been to survive, but she adds, "I have been honest with them, and most of all with myself. I'm who I am, and I like who I am."

In some of the stories, older people help the youngsters deal with the struggle to accept their sexual orientation. There is the stranger at the beach who tells one boy, "Just remember one thing—you're not alone." There is the Holocaust survivor who understands the meaning of prejudice and helps her granddaughter accept herself even though the girl's mother cannot, teaching the girl that "strangers take a long time to become acquainted, particularly when they are from the same family." There is the mother who helps her biracial lesbian daughter to self-acceptance, recognizing the evils of bigotry.

The target audience for *Am I Blue?* is young people aged twelve and older, who should, indeed, be encouraged to read this book for its upbeat quality and true-to-life stories. Parents, librarians, counselors, and teachers also should read it, as a way to increase their understanding of youngsters who are struggling with their sexual orientation, and as a departure point for discussion of sexual issues with young people.

Am I Blue? has garnered rave reviews from such disparate sources as the *Washington Post* and *Publishers Weekly.* Royalties are being shared with the Respect All Youth Program of Parents, Families and Friends of Lesbians and Gays (P-FLAG).

Reviewed by Elma Phillipson Cole, educational consultant.

LET'S TALK ABOUT SEX AND LOVING
Gail Jones Sanchez
Milpitas, CA: Empty Nest Press, 1994, 69 pages, $9.95

Parents and families who are committed to providing positive sexuality information to their children often have a substantial obstacle to overcome: since most adults never received comprehensive sexuality information, many still need to learn about proper terminology, body functions, reproductive organs and how they work, contraceptives, sexually transmitted diseases (STDs), and other fundamentals.

Let's Talk about Sex and Loving is a commendable source of sexuality information for both children and their family "sexuality instructors." The author, Gail Jones Sanchez, begins with a note to parents discussing when to start (she recommends at birth), how to proceed, and the importance of repetition. She goes on to explain the external and internal sexual organs of girls and boys, using correct terminology. An exceptionally thorough explanation of menstruation and wet dreams is followed by an explanation of sexual intercourse and childbirth. Although they are quite short, the sections dealing with masturbation and sexual curiosity reinforce the "naturalness" of each. Sanchez also covers parents' private time, "bathroom words," expressing anger, sexual abuse, adopted and foster children, and love and affection. The book contains a glossary; a list of resources; and a bibliography of sexuality information books for children, divided into recommended age groups.

The only objection I have to *Let's Talk about Sex and Loving* is that it seems to assume a heterosexual, traditional family audience. While the material is factual and accessible, the presentation excludes gay and lesbian relationships and nontraditional families; the material also perpetuates gender stereotypes.

Overall, I recommend this book as a resource for family sexuality education. Since it covers so many topics, I would further recommend that it be read to children in sections rather than in one sitting. The family members doing the reading/teaching should determine for themselves the age-appropriateness of the different topics (an approach the author also encourages in her note to parents).

One book will never contain or satisfy everyone's values, so I encourage families to look for books that contain the facts, like this one, and to clarify and teach values on their own.

Reviewed by Erica C. Neuman, Women's Institute on Sexuality, Health & Empowerment, Haslett, Michigan.

WOMEN, HIV AND AIDS
Hummingbird Films, 52 min., 1994.
Distributed by Filmmakers Library, 124 East 40th Street, New York, NY 10016.
$445 purchase, $75 rental.

This video is a compelling documentary about the complex ways HIV and AIDS affect women. It was produced for public television in Great Britain and is focused on Scotland, but its messages and concerns are applicable to women everywhere.

Much of the video's power comes from its documentary format, which features real people talking about their experiences as either consumers or providers of HIV-related services. The range of services represented, from street outreach to support groups and medical care for women who are HIV-positive, far exceeds what exists in most communities in this country. In that sense, *Women, HIV and AIDS* presents a vision of what is possible.

The discussions are frank and include subjects that commercial presentations about safer sexual behavior often ignore. One segment shows the members of a women's group talking about their sexual relationships with men and the realities of trying to insist on safer sexual practices. The women bring up issues of power and violence, and one participant notes that "there is a lot of 'skimming over' some very deep issues in discussions of safer sex."

A particularly strong segment takes place in an AIDS service organization that is exclusively for women. The agency's director notes that referrals have increased from one or two per week in 1989 to five or six per week, and that the proportion of women being infected through sexual intercourse has increased. She also discusses the deep emotional issues HIV raises for women in terms of their sexuality, relationships, families, and motherhood.

Dr. Mary Hepburn, an obstetrician-gynecologist with a community-based practice, describes how medical care *could* be provided in a respectful and patient-centered manner. Her clinic maintains close ties with social service agencies and helps to overcome women's fears that if they are HIV-positive and they seek help from the system, their children will be taken away from them.

The video also highlights the many forms of discrimination, prejudice, and blaming that surround women and HIV, as well as the specific concerns of Asian, African-American, and adolescent women. A short section dealing with lesbians is one of the weaker parts of the video and would have benefited from a more in-depth look at attitudes and behaviors.

The strength of *Women, HIV and AIDS* is that it speaks of truths that are too often ignored, and it demonstrates the links between the general status of women in Western culture and how this epidemic affects them. As one woman states, "I think this is the only medical condition which is surrounded by so much stigma, fear, ignorance and prejudice." The efforts of all of the women in this film to overcome that stigma make for a powerful presentation, and one that should be useful to many health and social service providers.

Reviewed by Mary Ruchinskas, director of the HIV Prevention Program at New Beginnings, an agency serving high-risk youth in Lewiston, Maine.

THE HANDBOOK OF FORENSIC SEXOLOGY: BIOMEDICAL & CRIMINOLOGICAL PERSPECTIVES
Edited by James J. Krivacska and John Money
Amherst, NY: Prometheus Books, 594 pp., $99.95

Why publishers insist on calling 600-page books, weighing several pounds, "handbooks" eludes me. But that observation aside, *The Handbook of Forensic Sexology* is a superb tome of encyclopedic scope encompassing the wide range of research on sexuality and its intersection with society's legal, judicial, and law enforcement systems. A wide range of experts contribute from their own perspective, whether it is medical, legal, psychological, sociological, philosophical, or other.

The editors are well chosen. James Krivacska is a clinical psychologist and director of the Children's Center of Monmouth County, New Jersey; John Money's name will be familiar to most readers of this journal as the author of several leading books on sexology and professor emeritus of pediatrics and medical psychology at Johns Hopkins School of Medicine. The editors, who provide introductory comments and articles of their own, have assembled a distinguished group of contributors, including professors Eli Coleman, Donald Mosher, and Richard Green. As in any collection of this kind, the chapters are of varying levels of comprehensiveness, clarity, and quality; yet, all are quite readable and add much to this topic.

The book is divided into three sections. The first examines paraphilic behaviors and how they have come to be labeled pathological, illegal, or both. This section covers sodomy laws, pedophilia, rape, sadomasochism, exhibitionism and voyeurism, autoerotic asphyxiation, prostitution, transsexualism, sexual harassment, and more. Many of these chapters are especially appropriate for, and geared toward, law enforcement officers and judges.

The middle section concentrates on current approaches to the assessment and treatment of sexual offenders and their victims. Among the areas addressed are sexual abuse and repressed memories, allegations of satanism and ritual sexual abuse, and the difficulties in assessing and treating both offenders and victims in the context of the legal system. The authors and editors are to be commended for not shying away from controversial and sensitive topics, such as false memory syndrome.

The third section addresses the impact that sexology can and should have in the formulation of social policy. Among the subjects discussed here are social policy, pornography, cross-cultural perspectives, sexuality education, contraception, and abortion. The ways in which these chapters examine the implication of society's actions in the realm of sexuality are especially good.

An invaluable reference for students, professionals, or scholars, *The Handbook of Forensic Sexology* would be a welcome addition to the bookshelf of policy makers, educators, health care workers, therapists, lawyers, law enforcement officers, judges, and anyone with an interest in or need to deal with any aspect of forensic sexology.

Reviewed by Peter Sandor Gardos, doctoral candidate in psychology, University of Connecticut.