SIECUS Report
Vol. 17 No. 1
September/October 1988
Sex Information and
Education Council of the U.S.

The Issue—and Controversy—Surrounding Adolescent Sexuality and Abstinence

Lynn Peterson

Two years ago, in 1986, I received a telephone call from The Center for Health Training (TCHT) in Seattle, Washington. The Center is a nonprofit corporation that provides training and consultation to Title X and other family planning programs throughout Washington, Oregon, Idaho, and Alaska. Additional regional TCHT offices are located in San Francisco, California; Austin, Texas; and Atlanta, Georgia. In addition to sponsoring regional continuing education conferences since 1972, TCHT offices have provided an annual calendar of events on clinical and administrative issues for family planning and primary care programs. They have also been involved in research and projects at the national level.

I was told that the Washington office of TCHT had just received a grant from the Office of Population Affairs, Department of Health and Human Services, to assist the State Family Planning Administrators (the people who direct family planning programs on a state level) with a project that was to focus on adolescent abstinence and that they were looking for a qualified person to coordinate this effort. Part of the job was to be the collection of educational materials from around the country and the creation of a bibliography on adolescent abstinence, which eventually would be distributed to all the family planning clinics in the United States.

I was thrilled with the possibility of securing a job—having just moved to Washington state—but reacted with dismay in respect to the topic. Adolescent abstinence? Certainly I was *for* adolescent abstinence. Wasn't I? Having worked within the family planning field, as an educator, counselor and trainer for more than 12 years, I have long been familiar with the high statistics of teen pregnancy and with the rising STD rates within the adolescent population. Nonetheless, I felt that something about this subject was foreign. It made me feel uncomfortable. I think I felt that by supporting adolescent abstinence I would quickly be looked at as one of "those" people: those people who deny the existence of adolescent sexuality; those people who are against sexuality education and abhor the thought of adolescents being able to walk through a clinic's door and receive contraceptives without their parent's permission. After all, I thought, aren't these the only people staunchly supporting adolescent abstinence? After hearing about the entire project and noting my reservations about the topic, I told my prospective boss that perhaps she really needed to hire someone that believed more strongly in adolescent abstinence. Her response was: "This is exactly why we want you to take the job. We think that you will look at all these issues with a critical eye."

I took the job with the Center for Health Training, became the coordinator for the State Family Planning Administrators' Project, The Adolescent Primary Abstinence Project (APAP), and officially began my journey into abstinence. In an effort to gather and explore available materials and approaches that could be used by teachers, family planning educators, and clinicians wishing to incorporate teenage abstinence into their work with adolescents, the staff and I began a national search for curricula, audiovisuals, pamphlets, and other resources that included abstinence as a topic or as an underlying supposition.

In March 1987, our project coordinated the State Administrators' national conference, "Focus '87: Adolescent

Abstinence," which featured several speakers representing programs and curricula promoting adolescent abstinence. And in March, we also issued our 16-page bibliography entitled *Helping Teens Wait. . .*which was then distributed to more than 5000 family planning clinics throughout the United States. In addition, I developed a two-hour workshop on abstinence issues which, to date, has been given 12 times to more than 1000 family planning professionals, teachers, and parents across the country. In this article, I will share some of the thoughts and feelings of workshop participants and attempt to reveal the patterns I see emerging in our educational messages to teens about abstinence.

I began the initial stages of the project by speaking to my colleagues and discovered right away that I was not alone in my thoughts and feelings about adolescent abstinence. Other helping professionals were voicing similar concerns:

> I'd like to support abstinence, but the teens think I am being judgmental. They just laugh.
>
> Sure, I have seen the figures that state that nearly 50% of teens have *not* had sexual intercourse—but they do not live in this town!
>
> Adolescent abstinence? Are you kidding? These teens *are* engaging in sexual activities! The "just say no" campaign is useless!

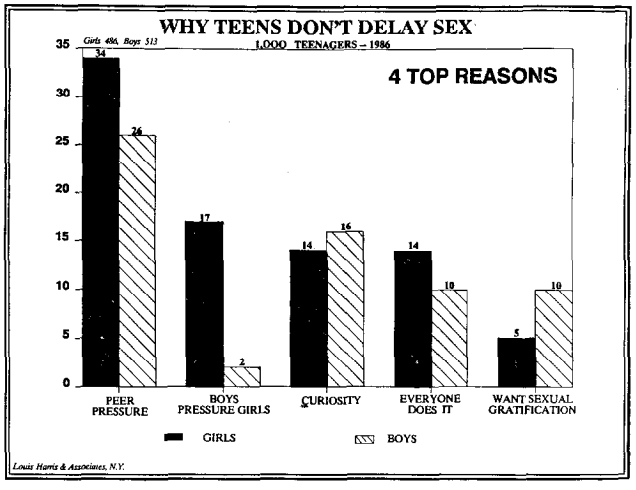
Some people, I found, felt caught in the middle:

> I talk about abstinence in my classroom, but I find that I hold back a little just in case there are teens who have already had sexual intercourse—because they may think I am being critical of them.
>
> My job responsibilities include providing contraceptive services to teens at the clinic. In my school or youth presentations, I am afraid that if I give too much support to abstinence the adolescents who need help with contraception may not come to the clinic.

In these statements lie the dilemma: Can we take a positive stand on abstinence and still provide guidance to those teens who are already engaging in sexual activities and are in need of services? If so, what approaches do we use in talking with them about abstinence?

In a 1986 poll, *American Teens Speak: Sex, Myths, TV and Birth Control,* conducted by Louis Harris and Associates for Planned Parenthood Federation of America, one thousand teens were asked their opinions on a number of issues. In the sexuality portion of the poll, they were asked: 1) Why do teens not wait to have sexual intercourse until they are older; and 2) What reasons are most useful in convincing peers to wait to have sex until they are older.

The top four reasons given for not waiting to have sexual intercourse by adolescent females were: peer pressure (34%); boys pressure girls (17%); curiosity (14%); and everyone does it (14%). Boys gave similar reasons: peer pressure (26%); curiosity (16%); everyone does it (10%); and sexual gratification (10%). Only 2% of the boys thought that boys pressure girls into it.



The most convincing arguments for waiting to have sexual intercourse revolved around the dangers of diseases, such as AIDS and herpes (65%), and the danger of pregnancy "ruining one's life" (62%). Fifty percent worried about what their parents would do if they found out, and 29% said that having sex would ruin their reputation with their friends. (One workshop participant, upon seeing the above survey results, contrasted them with the period in which she grew up, commenting: "When I was younger, those reasons would have been totally reversed. We were much more concerned about what our friends and parents would say. Disease was the last thing on our minds.")

What Is Meant By Abstinence?

In my workshop, "The Controversy Of Abstinence," I generally begin by asking the workshop participants to state the first idea that comes to their minds when they hear the word "abstinence." Their responses vary from saying that "abstinence is not having sex" and "abstinence is not having sexual intercourse" to "abstinence is giving something up, such as abstaining from eating sugar" and "abstinence is not having sexual contact." These definitions are obviously vague.

What are we really talking about when we say that teenagers should abstain? And what do we really mean by abstinence? Because our definitions of abstinence are varied, so are the messages that we give to teens about the subject. From our research of available resources, there appear to be three main ideological approaches to sexual activity that have been taken in abstinence programs. Even though these approaches can and do stand alone, they are often combined within one abstinence program. These approaches are:

1. Do not engage in sexual activities before marriage, because doing so is immoral.
2. Do not have intercourse until you are mature enough to prevent pregnancy and STDs.
3. Do not have intercourse until you have realized a certain level of full and positive sexual maturity.

1. Do not engage in sexual activities before marriage because doing so is immoral.

Some educators and parents believe that having sex before marriage is a sin. People who take this approach range from those merely trying to pass on to their children a deeply felt religious code to those who see any sexual contact beyond a simple goodnight kiss as the beginning of danger. As a strong supporter of parent-child communication, I applaud parents who are doing their job and are sharing their opinions and values about the right way to live one's life with their children. However, my concern lies with adults who wish, either directly or subconsciously, to promote guilt in those teens who have sexual thoughts and feelings and are presently given no basis for decision-making other than "just say no."

Curricula with this moral philosophy emphasize that individuals, who have a premarital sexual relationship or engage in "petting" in their teens, may permanently damage their capacity to experience true love as an adult. I believe that this approach produces guilt. These curricula further state that by having sexual contact one may scar so badly that she or he may never achieve true intimacy with a marriage partner.

These curricula also refuse to give accurate and clear information about contraceptives—and some give no information at all. The authors' feelings are that if abstinence until marriage is held as the ideal, then to give birth control information to teens is to promote the message: "We do not think that you *can* wait." Ironically, the same authors choose to include chapters on teen pregnancy. If, indeed, teenagers do not need to learn about contraception, why do they need to discuss what to do if they become pregnant? Also, does this not give a similar message to some: "We do not think that you *will* wait"? Moreover, when pregnancy options are discussed in one of the curricula, adoption after the baby is born is advocated as the only "right" choice; abortion is referred to as "killing the baby"; and it states: "in the long run, (if the couple choose abortion) they will feel guilt, depression, and anxiety."

It may be interesting to consider the possible long-term outcome for children who are raised with the approach that sex before marriage is immoral. Today, in this country, the average age for women and men to marry is in their mid-twenties—more than 10 years after the beginning of puberty. In the late 1800s, however, it was common for marriages to occur when the person was in his or her mid-teens. Couples were married and started having intercourse about the same time that they also began to experience their sexual drives. If adults today really want their children to wait until marriage before having sexual intercourse, then they must be prepared for the possibility that teens will marry early. Unfortunately, we also know that those who marry early (the late teens and early 20's) are also more likely to divorce.

Yes, there are people who wait until marriage to engage in sexual activities, and who live happily with that partner for the rest of their lives. And, as I have stated before, parents do have a responsibility to share their moral codes with their children. But, where in this "premarital sex is immoral" philosophy is there room for adolescents who are caught in a society that is sexually saturated and also

SIECUS Report

Vol. 17 No. 1

Editor, Janet Jamar
Executive Director, Debra Haffner

September/October 1988

The *SIECUS Report* is published bimonthly and distributed to SIECUS members, professionals, organizations, government officials, libraries, the media, and the general public.

Annual membership fees: Individual $60; Student (with validation) $30; Senior Citizen $40; Organization $100; (includes two bimonthly copies of the *SIECUS Report*) Library $60. *SIECUS Report* subscription alone, $55 a year. Outside the U.S., add $10 per year to these fees (except Canada and Mexico, $5). The *SIECUS Report* is available on microfilm from University Microfilm, 300 North Zeeb Road, Ann Arbor, MI 48106.

All article and review submissions, advertising, and publication inquiries should be addressed to:

Janet Jamar
Manager of Publications and Public Relations
SIECUS
32 Washington Place
New York, New York 10003

(212) 673-3850

Library of Congress catalog card number 72-627361.
ISSN: 0091-3995

sexually silent? (We are still not comfortable with providing comprehensive sexuality education for all of our children.) The situation is complicated by the fact that we live in a time when the sexual activity rates of teenagers are increasing. Moreover, many young males and females feel that there is something wrong with them if, by age 16, they have not "done it." For some, the message, "Don't have sex because I said so," is a safety net; but, for others, the guilt over their sexual feelings, and the outcome of not using contraceptives, leads them into a very painful adolescence.

2. Do not have intercourse until you are mature enough to prevent pregnancy and STDs.

This group, not as concerned about teenagers waiting until marriage to have intercourse, stresses a risk-related message about abstinence: "I know you probably will not wait until you are married to have intercourse, but at least wait until you are responsible enough to use contraceptives and to protect yourself from getting pregnant or a sexually transmitted disease." Many will argue that teens unable to seek out contraception are not mature enough to have a sexual relationship. But, obviously, the teenage pregnancy rate indicates that intelligent decision-making does not go hand-in-hand with sexual experimentation. The educators in this group are most concerned about the health risks related to early sexual intercourse. They fear, based on their experience with teens, that the consequences of becoming sexually active as an adolescent may seriously jeopardize a young person's future: his or her physical and emotional health, educational opportunities, and economic status.

The majority of curricula received in our national search falls into this view of abstinence. Learning units of such curricula generally include self-esteem, reproductive anatomy, family values, decision-making and contraception. Audiences of educators have expressed to me that teens want information about sexual response, masturbation, and homosexuality, but they also say that they steer clear of such controversial issues because parents may think these topics unsuitable for the classroom.

Historically, educators have prided themselves in teaching the subject of human sexuality in a value-free style, feeling that this is necessary because of the many different family value systems that are represented in their classrooms. But, do educators actually take a value-free approach? And should they? What should their role be in regard to the promotion of values?

Educators never have been, nor in my opinion should they be, value-free in their teaching of sexuality education. Adolescent development specialists propose that two of the primary tasks of adolescence are 1) establishing one's independence and 2) defining one's value system. Moreover, one of the first questions often asked by parents in an introduc-

Values Exercise for Workshop Participants

During the workshop, "The Controversy of Abstinence," Peterson finds it important to give participants an opportunity to examine their feelings on personal, professional, and societal values about issues related to abstinence and virginity. The audience is asked to stand up and come to a vacant part of the room. Then, one at a time, the following statements are read and people are asked to vote by moving to a place on the floor designated as "agree" or "disagree." In some cases, the choices are "have concerns" or "do not have concerns." After each statement, volunteers are asked to explain why they have responded in one way or another to the statements. The overall discussion that takes place on these points is usually lively and emphasizes the following:

1. As a parent of a 24-year-old daughter, I would have some concern if she was still a virgin. (have concerns, do not have concerns)

2. Your 24-year-old daughter comes to you and says: "Mom or Dad, I know that you feel that I should wait until I get married before I have sexual intercourse. Well, I have met a man and we are going to be married. He is 27 and a virgin too." Are you concerned about him marrying your daughter? (have concerns, do not have concerns)

The double standard. The double standard is still alive. When workshop participants were asked for their thoughts on their daughter's virginity, some expressed that they trusted her decision-making skills and that she would know when to begin a sexual relationship. Still others had concerns that their daughter might have been sexually molested as a child or traumatized in some way that may have produced a fear of intimacy. Thoughts about the virginity of the male in the scenario were somewhat different. Although some thought that he was just waiting until the right woman came along, many found his behavior suspicious. "If a 27-year-old man is still a virgin, he is either lying or there is something wrong with him." It appears that it is still more acceptable for young women to be virgins than it is for young men.

3. Society still believes that females who are virgins are worth more than females who are not virgins. Most people who strongly support abstinence are not really in touch with the world of today's teens. (agree, disagree)

Second virginity and virginity's worth. Some of the abstinence education curricula available promote an idea called "secondary virginity." This means that if one has had sexual

intercourse but decides it was a mistake, she/he can "redeem" herself/himself and become a secondary virgin. One participant wanted to know how many times that would work! Others thought that secondary virginity implied that those teens who had decided to have intercourse were second-class citizens, and that the phrase, therefore, was very judgmental.

4. Most people who strongly support abstinence are not really in touch with the world of today's teens. (agree, disagree)

Credibility and support of abstinence. Participants are split about whether or not one can strongly support abstinence and still be credible in most teens' minds. There is still fear about losing one's influence with teens when one promotes abstinence.

5. Family planning educators have always put enough emphasis on abstinence as a choice. (agree, disagree)

Progress in finding techniques for discussing abstinence. Although educators feel that at one time abstinence was not emphasized enough with teens, they do believe they are now making progress in finding ways to discuss the subject. However, most participants are discouraged and feel that no approach is very effective in convincing adolescents to abstain.

6. By giving teens information about contraception, other than abstinence, one gives them a double message. (agree, disagree)

A dual message is important. Only a few teachers and family planning workers believe that by giving teens information on contraception one may be condoning sexual involvement. Most all are united in the belief that a dual message, "Please wait. . . but if you do not wait, use birth control," is appropriate for teens.

7. Abstinence education should give teens information on the ways that one obtains sexual pleasure other than intercourse. (agree, disagree)

Information should not be censored. There seems to be general agreement among workshop attendees that teens should receive information about how one obtains sexual pleasure other than through intercourse. However, what they may believe is ideally covered in a sexuality course is often not what they can teach or discuss in the classroom. Many participants, who conduct youth presentations in schools, religious settings, and youth organizations, said that they are often unable to answer teens' questions about the subject of masturbation—or any other physical ways of expressing affection with one's partner—because of their fear that parents or administrators will consider this to be "sex instruction."

tory session with a sexuality teacher is, "What are the values you are teaching my children?" Educators can, and do, address value issues. What is important in teaching values is that one should not proselytize a particular point of view.

Teachers and family planning staff can strongly support, in any program, universal values such as respect for oneself and others, honesty in relationships, and the destructiveness of sexual coercion. These values, and others accepted by the vast majority of adults, can help teens feel good about themselves as they establish their independence and choose what is right or wrong within their particular value systems. The challenge for educators, teaching from a philosophy that clearly delineates "right" and "wrong" behaviors, is to teach the values their program supports in a nonjudgmental way.

Until these educators clearly decide how to incorporate values into the curricula, their lesson plans will primarily focus on the message that the risks of sexual intercourse are too great. Their message thus is: abstain. Fortunately, however, the curricula of this group, for the most part, do attempt to provide additional help for teens who are taking these risks. They state: "If you decide to go ahead, plan to use contraceptives and be responsible."

3. Do not have intercourse until you have realized a certain level of full and positive sexual maturity.

Some parents and educators are examining their approach to the subject of abstinence. They are asking themselves the question: "What are we trying to prevent and what are we trying to promote?" They are not using abstinence as much to prevent immoral behavior, or because of the health risks, as they are to help youth develop positive sexual maturity. They are not arguing against preventing teens from having babies too early or against avoiding the dangers of chlamydia, herpes, and HIV infection, etc., but they are choosing, instead, to concentrate on building positive sexuality attitudes. Rather than focusing on the negative message, "Don't have sex," they are talking with teens about how and when to say "yes" to sexual behaviors but "no" to intercourse.

People in this group support healthy sexual development for teens which includes an appropriate exploration of physical intimacy between couples. However, they are asking their children to delay having intercourse until they have developed a certain level of positive sexual maturity. The question they are asking adolescents to consider is: "What conditions need to exist in a relationship before one can feel totally comfortable saying 'yes' to any sexual involvement?" In addition, they are assisting young people in developing a checklist of these conditions which generally includes a meaningful understanding and personal definition of intimacy—both physical and spiritual.

I serve on a local group called The Task Force on Positive Teenage Sexuality which is sponsored by our local county's chapter of the American Red Cross. The Task Force is composed of individuals from both sides of the abortion debate who have chosen to find common ground in supporting activities promoting positive teenage sexuality. Although, we do not agree on the definition of positive teenage sexuality, we do agree that young teenagers should ideally not have sexual intercourse. A local pediatrician on the task force, however, whom I classify as being a member of the third major approach in abstinence education, suggested the following criteria by which some adults might condone an adolescent sexual relationship:

- The relationship is based on mutual respect and long-term commitment.
- Feelings are valued and shared.
- There are many common interests and friends, yet there is also the freedom to develop individual interests.
- Completion of developmental tasks of adolescence (self-identity, development of a value system, independence, capacity to form intimate relationships, goal setting) are enhanced through the relationship.
- There is comfort with sexual intimacy, that is, it is mutually acceptable and nonexploitive.
- Sexual feelings and facts (STDs and contraception) are freely shared.
- Both persons are able and willing to avoid STD and pregnancy.
- Sexual activity is not the focus of the relationship.

The above list, interestingly, provides the basis, in my opinion, of a mature love relationship. Those that believe that teens need to reach a certain level of full and positive sexual maturity before engaging in sexual intercourse would probably agree that this list is supportive of that goal.

The Educational Approaches Now Used in Regard to Abstinence

Even though educators are still struggling with how to define abstinence and their own personal motives for teaching it, they, nonetheless, are presently using several approaches to abstinence education.

Focusing on Health Concerns

One of the educational approaches used in teaching teens about abstinence is based on what teens, themselves, say is a convincing argument. According to the teens in the 1986 Harris poll already cited, educators should speak out about the health risks related to early teenage sexual activity and STDs. Although some educators feel that this is using "scare tactics," teens say that hearing about these consequences does make a difference to them. Certainly, given today's concerns about HIV transmission and other STDs, many educators are choosing to strengthen the abstinence message with information about health risks.

RESOURCES

In the bibliography, *Helping Teens Wait. . .*, more than 60 curricula, audiovisuals, brochures, and miscellaneous resources are listed that have abstinence as a part of their message. Educators selecting from these materials will need to evaluate them according to the criteria established by their agency and/or community. The following are some resources from the bibliography that Peterson suggests merit individual attention.

General Curricula

VALUES AND CHOICES
This curriculum is aimed at 7th and 8th grade students and contains fifteen lessons based on seven basic values: equality, honesty, respect, responsibility, promise-keeping, self-control and social justice. Lively and informative videotaped segments are used to help with lesson topics that include puberty, sexism and stereotypes, dating, saying no, pregnancy and birth, and teenage pregnancy. Three parallel sessions exist for parent participation. A 150-page supplemental guide, *YES YOU CAN! Affirming Sexual Abstinence Among Young Teenagers,* provides information on gaining community support for sexuality education, helpful hints for first-time teachers, and the results of research conducted on the program. *Search Institute*, 122 W. Franklin, #525, Minneapolis, MN 55404, (612) 870-9511.

Curricula for Parents and Children Together

PARENTS AND ADOLESCENTS CAN TALK (PACT)
PACT is a community-based communication and sexuality education program for adolescents, preadolescents, and their parents. The programs, designed in two separate curricula (5th-6th graders and their parents) and (7th-9th graders and their parents) are divided into a series of lessons focusing on self-esteem, parent/adolescent communication, assertiveness, decision-making, and knowledge and values toward sexuality. A Peer Facilitator Training Curriculum exists to train volunteers to lead the program. *PACT Project*, Department of Home Economics, 316C Herrick Hall, Montana State University, Bozeman, MT 59717 (406) 994-4981.

Audiovisuals

IT ONLY TAKES ONCE
"It Only Takes Once" is hosted by a black teenager who "knows what's happening" in her high school and combines humor with serious stories of teenagers who had to "grow up real fast." Although the film addresses the implications of a teen pregnancy, it also discusses the myths that can lead to early sexual activity and pregnancy. Abstinence, as a very real and effective option, is the theme promoted throughout the film by the males and females. Contraceptives are briefly mentioned. A discussion guide accompanies the video. *Intermedia*, 1600 Dexter Avenue North, Seattle, WA 98109, 1-800-443-0100 Ext.320, (206)282-7262.

MAKING RESPONSIBLE DECISIONS – A ONE ACT PLAY
This is a videotape of a play that focuses on a young man who is experiencing pressures from society and peers to become sexually involved with his girlfriend. This dilemma produces many conflicts that are eventually solved. The tape also conveys information about responsible decision-making, family planning, and assertiveness skills needed for "saying no." A guide for the leader provides discussion questions and activities to use with the video. The script is also included for those who would like to produce the play. *The Emory/Grady Teen Services Program*, Box 26158, Grady Memorial Hospital, 80 Butler Street SE, Atlanta, GA 30335, (404) 589-4202.

SEX AND DECISIONS: REMEMBER TOMORROW
When two teens manage, through a set of circumstances, to have a day together at a beach house, they must decide whether to have sex or not. The film follows them through the day as they face temptation – and resist. In the end, we step back into reality and see the characters step out and explain how they faced an important question and made their decision. *Perennial Education, Inc.*, 930 Pitner Avenue, Evanston, IL 60202, 1-800-323-9084.

HOW CAN I TELL IF I'M REALLY IN LOVE?
Hosted by Justine Bateman (Family Ties) with appearance by Jason Bateman (Valerie) and Ted Danson (Cheers), this humorous and fast-moving video talks about intimacy and sexuality. Questions are answered such as "How do you know if it's love?," "Can you confuse chemistry with love?," "Is sex love?," and, "Is sex the real turn-on, or is it intimacy?" Teens are given clues to help them evaluate their relationships and suggestions for strategies to use to resist sexual pressures. *Ed-U Press*, 7174 Mott Road, Fayetteville, NY 13066, (315)637-9524.

Brochures

Should We? Hawaii Planned Parenthood, 1164 Bishop Street, Suite 1220, Honolulu, HI 96813, (808)521-6991. Price $.50 each. In bulk add 15% for p/h.

Knowing How to Say NO. Clallam Jefferson Family Planning, 1215 East 1st, Port Angeles, WA 98362, (206) 452-2954. Price 1-49, $.20 each; 50-199, $.18 each; 200-499, $.16 each; 500 copies, $.15 each. Add 15% p/h.

Teensex? It's Okay to Say: NO WAY! Planned Parenthood of America, Inc., 810 Seventh Avenue, New York, NY 10019, (212) 541-7800. Price $.50 each; 100, $25; 1000, $180.

The *HELPING TEENS WAIT. . .* bibliography is available from The Center for Health Training, 400 Tower Building, 1809 Seventh Avenue, Seattle, WA 98101, (206)447-9538, for $3.95 each (bulk prices available on request).

Focusing on Parent-Child Communication

We know from research studies that the lowest prevalence of sexual intercourse among 15 to 16-year-olds is associated with the joint occasion of sexuality education and communication between parents and their children (Furstenberg, 1985). Parent seminars and parent-child sexuality classes are offered by family planning programs, community groups, and religious organizations in many communities around the country. These programs can and should help parents to articulate the value they put on abstinence and help them to define, for their teens, exactly what they expect them to abstain from. Although the task of recruiting parents for such programs remains difficult, it is often made easier by the inclusion of an abstinence focus or component. The benefits are many. Parents, hesitant about supporting sexuality education, often will support classes that have been designed to include them. Also, educators are finding ways to involve parents in teen groups, sexuality education classes, and through assigned homework for both parents and students. It is quite clear that activities that increase parent-child communication about sexuality also facilitate opportunities for parents to share their values and expectations with their children.

Focusing on Teaching Refusal Skills

Pressures to engage in sex are strong during the teen years. One-quarter of the teens interviewed in the 1986 Harris Poll reported that they felt pressured by other teenagers to go further with sex than they wanted. *Both* genders felt this pressure, with girls only slightly more likely to report pressure (28%) than boys (21%). Many curricula contain activities which help teens learn how to resist this sexual pressure. Often such programs also empower youth to resist peer pressure urging them to participate in other risky behaviors, including drug use, shoplifting, etc. as well. Such assertiveness skills have lifelong value. However, we need to be alert to teens' concerns where resisting peer pressure is involved. It is not always easy to say "no" even after learning the skill. Some teens struggle with a recurring problem: "It is easy to say 'no' to a creep. It is much harder when it is someone you really care about."

Focusing on Teaching Decision-Making Skills

Some educators bring the abstinence message into focus by taking teens through the process of learning good decision-making skills. Discussing with teens the pros and cons of teenage sexual activity, for example, tends to validate their feelings that the pressures to have intercourse exist and are very real. When asked why some teens decide to go ahead and have sex, teens' answers include: "Because they are in love," "Because they want to have a baby," "Because their partner wants them to," and "Because it is natural." Although some of these reasons seem faulty to adults, they appear legitimate to teens. By allowing adolescents time to struggle with decision-making, educators can open up

discussion on whether or not the reasons they give for having sex are good. Such questions can be put to them as: How does a person know when he/she is ready for sexual intimacy?; What should a person consider in making the decision whether or not to have sexual intercourse?; and, Are teens ready to be parents? When free discussion is allowed, educators find that teenagers can list more valid reasons for postponing intercourse than for going ahead. Helping adolescents develop decision-making skills gives them power to see situations in a new light. It also enables educators to point out the link between decisions made now and future plans for family, for jobs and careers, and for life goals. Perhaps, most importantly, if teens themselves conclude that intercourse should be delayed, they are more likely to behave consistently with that decision.

Conclusion

In 1987, the State Family Planning Administrators conducted a survey of the country's Title X family planning clinics. Ninety-four percent of the respondents reported that they would benefit from having more educational materials which focus on talking with adolescents about abstinence. Ninety percent felt that staff would benefit by having additional training on how to talk with adolescents.

With all the perceived and/or real barriers to discussing abstinence with teens, it is still apparent that educators want to reach out, in a nonjudgmental way, to help teens search for the real answers to the very hard questions that they face in regard to their sexual activities. With that in mind, and as a follow-up to the survey, the State Family Planning Administrators Project produced a booklet "Adolescent Abstinence: A Guide for Family Planning Professionals." This publication lists educational and clinical approaches that can be used when talking with teens.

I do not cringe as much now as I did two years ago when I think about the subject of adolescent abstinence. What I realize is that we have been offering abstinence education all along in our work as educators and family planning professionals. We may have been using different labels, but this subject is not new to us. Thus, the answer to the question, "Can educators, youth workers, and family planning professionals support and promote the discussion of abstinence and continue to offer high quality clinical services to those teens who need services?," is "yes." We can do this by:

- Encouraging teens to make healthy decisions for themselves.
- Giving straight facts about the health concerns of teen pregnancy and STDs.
- Supporting those teens who have chosen abstinence.
- Strengthening communication between parents and their children.
- Supporting comprehensive sexuality education that involves parents and community leaders.
- Offering quality counseling and medical services to those teens who call for help.

A colleague of mine, Dr. Dennis Dailey of the School of Social Welfare, University of Kansas, in Lawrence, Kansas, once told me a true story that I think provides a special perspective on adolescent abstinence.

Dr. Dailey recieved a telephone call from a local church official requesting that he come and talk to their teen group about "not having sex." Dailey, in response, asked if he could first speak to the parents. The church offical agreed.

Meeting with the parents later, he introduced himself, and said, "I understand that you have asked me to talk to your teens about not having sex." He then said, "My answer is no," and sat down. The parents were caught somewhat off-guard. Dr. Dailey then stood up again and said: "If you want me to speak with your kids about how to be good lovers, then I will be happy to come and speak to them." The parents were noticeably uncomfortable. They had asked him to talk to their children about *not* having sex, now this man was recommending that he come and give their children "sex instruction." Dr. Dailey, interrupting their thoughts, said, "Do you want your children never to have sex?" A parent, somewhat relieved, replied, "Oh, that is not what we meant. We just do not want them to get hurt or pregnant." "But don't you see," Dr. Dailey continued. "A good lover would never manipulate a partner into a situation which would intentionally cause pain. A good lover would never purposely expose his or her partner to a sexually transmitted disease or to the risk of an unplanned pregnancy. A good lover would only want what is best for that partner." The adults were very quiet. Now they knew what he was trying to say, and they asked him to speak to their youth group as soon as possible.

After 12 years as a parent and as a professional sexuality educator, I am still working on my own definition of abstinence and I am still struggling to find the best educational method for integrating abstinence into sexuality education. However, in my mind I have concluded that bringing up a child—a daughter or a son—to be a good lover is not inconsistent with teaching abstinence to teens.

Reference

Furstenberg, Jr., F.F. Moore, K.A. & Peterson, J.L. Sex education and sexual experience among adolescents. *American Journal of Public Health,* 1985, 75(1) 1331-1332.

Lynn Peterson, MS, works as a family life educator and is coordinator of the State Family Planning Administrators Project at The Center for Health Training in Seattle, Washington.

Safe Sex and Teens

Debra W. Haffner

As a Planned Parenthood educator in the early 1980s, I often began my classroom contraceptive presentations, "Today we are going to talk about contraception. Before we do that, it is important to recognize that only about half of you are currently sexually active, and many of you won't need this information for a long time. It is important that you get this information now before you need it and so that you can share it with a family member or friend."

I would continue, "There are many ways for people to share sexual pleasure. There are kissing, and talking, and handholding. . . now let's talk about birth control." I always knew what I was leaving out, and I suspect that many of the students did too. Although I had been asked to talk about each of the methods of contraception and was often able to be quite explicit in doing so, I knew that the teacher and the school might have been aghast had I talked about the complete range of sexual behaviors.

As I have conducted training workshops for professionals around the country, I usually include a section on values clarification around adolescent sexual behavior. Two areas are always particularly problematic. One has to do with what the appropriate age is for a teenager to first have sexual intercourse. (This is often correlated with the age the participant first had sexual intercourse.) The other is reactions to the statement, "We should teach teens about oral sex and mutual masturbation in order to help them delay the onset of sexual intercourse and its resulting consequences." Educators are often quite vehement in their opposition to actually talking with young people about sexual behaviors.

Such silence often helps reinforce the message that one goes from kissing and hugging to activities that require the use of contraceptive methods, i.e., vaginal intercourse. The message our young people see in the movies and on television is the same—characters kiss and in the next scene they are in bed, usually relaxing after they have had intercourse. We only rarely see any type of courting or sex play. We are teaching our children that you either stop at kissing or you "do it."

Little wonder then that research studies have shown that many of our teenagers are engaging in sexual intercourse without even removing their clothes. Many young women and young men report that they have intercourse without any type of foreplay, and countless young women have told me in counseling sessions that they have never had an orgasm with their sex partner.

As discussed in the Peterson article, the cries for total abstinence for teens have done little to change teen behaviors. In fact, a recent study by the Alan Guttmacher Institute shows that sexual activity among unmarried women has actually increased over the past five years, despite the AIDS scare campaigns and "just say no" programs for our young people. I cannot help but wonder what programs that teach that sex equates with death are doing to our young people's developing sense of sexual identity. As Dr. Joseph A. Cantania, a scientist at the University of California at San Francisco, said at a recent meeting at the University of Vermont, "Bang, you're dead—what kind of message is that? We're creating a generation that will be going to sex therapists for years."

As a society, we need to begin to accept that the vast majority of young people engage in some type of sexual activity during adolescence, and only some of that activity is sexual intercourse. Even among the 20-30% of teens who are still virgins at 19, almost all have experimented with sex. Forming a sexual identity is a critical developmental task of adolescence.

Colleagues and I have fantasized about a national "petting project" for teenagers. The object would not be to increase petting among teenagers, but to help them learn courting behaviors and to, once again, give teens time to learn slowly about their sexuality. I am not advocating a return to the days of technical virginity, but rather to an unhurried and unpressured norm of teen sexual activity.

Many of my friends and colleagues report fond memories of having limits on their adolescent sexual behavior. The "bases" dictated how far one would go and in what kind of relationship. There was time for hours and hours of kissing without the pressure to "go further." More advanced sexual activities were related to the development of intimacy.

Today's teens also need to have that opportunity for unpressured discovery of sexual feelings and responses. We need to tell teens that the safest sex doesn't necessarily mean no sex, but rather behaviors that have no possibility of causing a pregnancy or a sexually transmitted disease. A partial list of safe sex practices for teens could include:

Talking
Flirting
Dancing
Hugging
Kissing
Necking
Massaging
Caressing
Undressing each other
Masturbation alone
Masturbation in front of a partner
Mutual masturbation

Teens could surely come up with their own list of activities. By helping teens explore the full range of safe sexual behaviors, we may help to raise a generation of adults that do not equate sex with intercourse, or intercourse with vaginal orgasm, as the goal of sex. Rather, we can help teens understand that sex is more than intercourse and that abstinence from intercourse does not mean abstinence from all intimate expression.

The Sex Respect Curriculum: Is 'Just Say No' Effective?

Susan N. Wilson and Catherine A. Sanderson

The last eight years have seen significant efforts to reduce teenage pregnancy and sexually transmitted diseases by halting sexual activity among adolescents. Among the sex education curricula focused on abstinence, the most extreme is *Sex Respect: The Option of True Sexual Freedom*. This program was designed by Coleen Kelly Mast, a family life educator with a Masters of Science in Health Education, and was funded by the United States Department of Health and Human Services.

Sex Respect includes workbooks for teachers, parents, and students, (priced at $12.95, $8.95, and $7.95, respectively). Each workbook contains ten chapters: Sex: What We Are and What a Difference; Who's in Charge Here? Mind Over Matter; Free Sex: Is It? Or Isn't It?; Who's Kidding Whom?; Sex on Credit: Play Now, Pay Later; You Can Have It All! Go For It!; Dating: The Chance of a Lifetime! Don't Blow It; Staying Cool—It's Never Too Late; Fatherhood/Motherhood: Are You Ready?; and It's a Wrap.

Endorsed by Right to Life, *Sex Respect* has been implemented in over 300 high schools and by several churches in the last three years. The Arizona State Legislature is currently considering mandating *Sex Respect* for all public schools in that state.

Sex Respect teaches skills which should be part of all sex education programs. Assertiveness, for example, is well defined in the curriculum: "It's the ability to set limits and then keep to them. It's being in control of a situation, letting others know you mean what you say," (p. 44). Exercises include practicing assertive "comebacks" to lines about sex and role-playing assertive behavior in different situations. *Sex Respect* supports teenagers who choose to abstain from sex and emphasizes that abstinence is acceptable: "young men and women should feel entirely free to say 'no' without the least anxiety about being normal," (p. 39). The curriculum also discusses self-confidence, maintaining a positive self-image, and responsible decision-making.

However, *Sex Respect* limits the application of these skills to "always say no" situations. Experts in child growth and development recommend allowing young people to make their own decisions. But, radical programs like *Sex Respect* dictate "correct" choices and condemn alternatives. Such authoritative teaching techniques have been negatively correlated with reasoning, planning, memory, and IQ skills.[1] Limiting the child or adolescent's natural tendency to explore, question, and ultimately come to his or her own conclusions, stifles autonomy and a sense of self. Students can be offered learning activities which provide intellectual exploration and flexibility, within a supportive, encouraging environment.[2] Young people need to learn to be assertive when they feel uncomfortable in sexual and other situations. They also need to know that their limits may change depending on the partner, the circumstance, and the level of comfort.[3]

Sex Respect, on the other hand, instructs teenagers to "say no" to all premarital sexual activity. Catchy phrases are used to emphasize this point: "Control your urgin', be a virgin," "Don't be a louse, wait for your spouse," and, "Do the right thing, wait for the ring." These slogans leave adolescents no choice and rob them of decision-making and responsibility. Sex education programs can empower adolescents by supporting the decision to say "yes" as well as "no." In *Sex Respect*, the adolescent's ability to make decisions is only valued when the "right" choice is made. This approach rejects information in favor of ideology.[4]

Sex Respect links sex with guilt, fear, and shame. According to the guide, there is "no way to have premarital sex without hurting someone." The curriculum instructs that "the pattern of petting and stopping. . .can cause an association in our mind between petting and frustration [and these] negative memories formed from past habits can still prevent us from fully enjoying the physical side of marriage," (p. 23). The guide's chart of physical intimacy marks even a "prolonged kiss" as the "beginning of danger," and advises "no petting if you want to be free," (p. 19). The wildly exaggerated "dangers of single dating" are enumerated: neglecting friends, feeling trapped, being controlled, getting possessive, being hurt, seeing every member of the opposite sex only as a potential date and missing out on some good friendships (p. 35).

By using the "Just Say No" slogan, associated with anti-drug campaigns, the curriculum confuses physical addiction with physical desire. Mixing negative messages about illegal and dangerous drugs with sexuality ignores the positive aspects of sexual intimacy. Sexuality offers the redeeming values of love and relationships which illegal drugs do not.[5]

The curriculum gives "SEX TIPS FOR A SAFE DATE: KEEP ALL of your clothes ALL the way on ALL of the time. DON'T LET ANY part of ANYONE else's body get ANY where between you and your clothes. AVOID AROUSAL," (p. 19). Such negative attitudes do not discourage sexual activity, but do discourage responsible birth control.[6] *Sex Respect* avoids any mention of a "sexuality of desire."[7] Intimacy, pleasure, and closeness are ignored in favor of the often inaccurate and "dangerous" details of premarital sex.

Sex Respect repeatedly emphasizes the negative aspects of teenage pregnancy yet fails to provide any information about birth control. Contraceptives are mentioned only once, as the answer to a fill-in-the-blank quiz: "____ are supposed to prevent pregnancy, but don't always do so," (p. 15). Studies in other countries have repeatedly shown that without accurate, available birth control information, teenage pregnancy rates increase dramatically.[8] Although teenage sexual activity in the United States is approximately the same as in Sweden, France, and Norway, the rates of teenage pregnancy, births, and abortion are considerably higher in the United States.[9]

A recent study in one South Carolina county demonstrated that effective teenage pregnancy prevention includes practical information about contraception.[10] This intervention program, designed to reduce unintended pregnancies among unmarried adolescents, has been highly successful. The information—targeted at parents, teachers, children, and religious and community leaders—included decision-making and communication skills, self-esteem enhancement, human reproductive anatomy, physiology, and contraception. Pregnancy rates among 14 to 17-year-olds declined from 60.6 per year in 1981-82 (before the intervention) to 25.1 in 1984-85. During the same period a comparison count showed a 5.5 increase in pregnancies, from 52.9 to 58.3. These results clearly show that practical birth control information is an integral component of effective sex education programs.

The traditional, sexist attitudes of the *Sex Respect* curriculum are particularly disturbing. The "inherent differences" between men and women are emphasized repeatedly in skits and dialogues. "In fact, a male can experience complete sexual release with a woman he doesn't like," the guide reports, "whereas a woman usually can't do so unless she loves her partner," (p. 4). Reinforcing this inaccurate information, *Sex Respect* quotes fictitious females saying, "I don't enjoy doing it anyway," thus denying a woman's right to enjoy sexual intimacy. Myths about male sexuality appear as well: "Young males are tempted to. . . aggressively seek sexual release with whatever person they can persuade or force to accommodate them," (p. 4). These comments portray females as victims and all males as potential predators, creating serious misconceptions about male and female sexuality and reinforcing unhealthy and sexist stereotypes."[11]

The religious overtones of *Sex Respect* are problematic for a public school sex education curriculum. These include views about premarital sex based entirely on opinion: "Many men and women still prefer to marry virgins," for example. Similarly, the comments about abortion are misleading and inaccurate. The guide cites the general problems of heavy loss of blood, infection, puncturing of the uterus, infertility, and an increased risk of miscarriage with future pregnancies, whereas these problems usually occur only in late abortions. In fact, medical morbidity and mortality rates arising from full-term adolescent pregnancy are much greater than those arising from adolescent abortion.[12] In addition, the psychological risks entailed in adolescent completion of pregnancy are substantially greater than the psychological risks of adolescent abortion.[13] Once again, *Sex Respect* fails to provide accurate information and insists on dictating the "correct" choice, irrespective of the situation or the teenager's desires.

Sex Respect fails because it does not follow the principles of child development. The curriculum is overwhelmingly negative about sexuality and distrustful of adolescents. In order to reduce pregnancy and sexually transmitted diseases among adolescents, a balanced, positive curriculum is necessary. The program should trust and empower young people.

Those countries that have reduced teenage pregnancy rates have a goal to prevent teenage pregnancy; in the United States, the government has a goal of preventing teenage sexual activity. *Sex Respect* does not reflect the world we live in, a world in which 70% of teenage girls and 80% of teenage boys are sexually active.[14] This curriculum ignores the last 40 years—the feminist revolution, the birth control revolution, the sexual revolution—in favor of an ideology of the 1950s. Denying that young people are sexual beings is not an effective approach to the problem of teenage pregnancy.

Footnotes

1. McGillicuddy-DeLisi, A.V. Parental beliefs about developmental processes. *Human Development,* 1982, 25, 192-200.
2. Sigel, I.E. Does hothousing rob children of their childhood? *Early Childhood Research Quarterly,* 1987, 2, 211-225.
3. Brick, P. Sexuality today: An institute for educators and counselors. Rutgers University, New Brunswick, New Jersey, July 25-28, 1988.
4. Ibid., Sigel.
5. Westheimer, R. & Lieberman, L. Sex and morality: Who is teaching our sex standards? New York: Harcourt Brace Jovanovich Inc., 1988.
6. Hatcher, R.A., et al. Contraceptive technology 1988-1989. New York: Irvington Publishers, Inc., 1988.
7. Fine, M. Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review,* 1988, 58(1), 29-53.
8. Ibid., Hatcher, et al.
9. Jones, E., et al. Teenage pregnancy in developed countries: Determinants and policy implications. *Family Planning Perspectives, 1985, 17(2), 55-63.*
10. Vincent, M.L., Clearie, A.F. & Schluchter, M.D. Reducing adolescent pregnancy through school and community-based education. *JAMA,* 1987, 257 (24), 3382-3386.
11. Ibid., Fine.

(Continued on page 19)

Assessing the Health of Sex Education in a Time of Dis-Ease

The S.U.R.E. Method

David McAllister

As a sexual health educator for a large metropolitan health department, I visit many different educational settings, formal and informal, in a variety of communities. They all share one thing in common: they are scared by the human immunodeficiency virus (HIV) as they never have been scared by any sexually transmitted disease (STD) before—and they are turning to sex educators for understanding and protection. HIV infection is also the number one concern of the students who register for the college classes I teach on human sexuality. Moreover, the sex educators attending my conference workshops and teacher-training sessions are often frightened themselves. Thus, the public not only has this terrible disease to deal with, but they also have to deal with our dis-ease with AIDS as well.

For sex educators, the lesson is that the deeper the crisis the more we need to return to the inspiration that led us into this field in the first place: that sex is a pervasive, abiding, and positive force in life. Our goal should be the promotion of a sex-positive paradigm through sex-positive messages and sex positive attitudes, that will promote sex-positive behaviors that will lead to sex-positive lives. Our shared purpose should be to keep the healthy sex-positive view safe and flourishing in a world in which it is threatened.

Although we may think of this as a particularly modern problem, the history of sex education has been a series of responses to each era's dis-ease with human sexuality. Thus far in history, sex education has been remedial. We always arrive "late" as sex educators, after much mislearning has already been allowed to take place. Unfortunately, a high degree of mislearning is common because instruction, role models, and practice (the opportunities to explore, experiment, and make mistakes) have most often been denied.

The SURE Method

Dr. derek calderwood's proscription for remedial sex education is the four-phase SURE method: Self-evaluation, Unlearning, Relearning, and Exercise (Brown, 1981). The first stage is to become "self-evaluative" of what is needed and wanted. Since we arrived late, mislearnings must be "unlearned" in the second phase before our educational messages can even be heard. Only then is the third phase, "relearning," possible. "Exercise" is the pivotal phase of the process where the ongoing fit of what is learned is evaluated within the living context of broad personal, social, ethical, and spiritual values. If the new learning is found wanting, it is spiraled back into the SURE process which is begun again. I will now apply an abbreviated SURE model to a few issues of consequence for sex education today, while also introducing some techniques that have been found useful by contemporary sex educators.

1. The Self-Evaluation Phase

To illustrate the self-evaluation phase, I would like to lead you through a brief phenomenological investigation of some language in common usage: "personal safety" with its buzzword "strangerdanger"; "sexual addiction"; "safe" and "safer sex"; and "just say no." To conduct a phenomenological investigation, we must temporarily distance ourselves from the comfortable familiarity of these words. Become skeptical. Get suspicious of these words. Be unsure of their appropriateness. Don't take their meanings for granted. In fact, take them entirely out of context and see what flavor they have standing on their own. What are the kinds of things one might "just say no" to? What kind of thinking or decision-making skills are being exercised? What feelings about others are engendered by "strangerdanger"? What is your image of an "addict" and his or her "addiction"? How do these words relate to our images of sexuality? As for the words "safe" or "safer sex," and "personal safety," what does making safety a sexual issue say about sex? I think you can begin to see how this phenomenological investigation can objectively disclose the burden of negativity these words impose on their referents.

Let us now look at what might happen in their absence. Once disabused of the term "strangerdanger," relationships with people already known by a child will no longer be wrongly held above scrutiny. If we do not qualify sex as "safe" or "safer," we are no longer implying that sex is inherently dangerous. What is dangerous, in this case, are the infectious parameters of a particular, albeit serious, virus. Negative bias, in common usage, is often the glue that holds public misinformation in place.

2. The Unlearning Phase

To illustrate the unlearning phase, I would like to recreate an experiential process that took place with a mixed group of students, parents, and teachers-in-training. While only the students participated, everyone in the room was moved by this experience. I began by placing two empty chairs in front of the room. I then asked the students to imagine themselves sitting on those two chairs, facing their ideal dates. To make it more real for each of them, I asked them to add descriptive details of their date's clothing, hairstyle, etc.

They were then asked to call out the type of advice they thought they would get, from different people, about the issue of teenage intercourse. Asked what they thought a sex educator's advice would be, pleas of "It's OK to say no" and "Only if you're ready," and injunctions, such as "Be careful" and "Use birth control," rang out in the room. When asked what advice they thought their parents would give them, prohibitions ran the emotional gamut, climaxing with "If you do, I'll kill you." When asked to switch from parents to peers for advice, all the students shouted in unison, as if they had rehearsed: "Go for it!" Further advice also was elicited from individuals representing other interests (medical, religious, etc.).

All of us were soon oversaturated with the sounds of the disparate, and often conflicting, advice that was now ringing in our ears. I turned to the whole group—bringing in the parents and teachers-in-training—and made the point: the one thing that none of us needs right now is another piece of good advice—no matter how well-intended or well-founded. Students, in fact, most often need to unlearn what they have been told just to reclaim their status as learners.

I next asked the students to express their personal concerns about premature intercourse. Some of their concerns were as follows:

What will my family think?
What if we get caught or found out?
What will my date think of me now?
What about pregnancy?
What will my friends say?
What about STDs?
Will my date expect it every time now?
Did I do it right?
Am I normal?

As they called out each of these, I placed a large object on the two chairs—such as a box, briefcase, coat, or umbrella—to represent their responses. Soon the chairs could hold no more. When I pointed out that now there was also no room left on the chairs for the imaginary couple, the room immediately became very quiet. When asked why they were so quiet, they responded with some variation of the idea that the whole point of being loved is to be really known and loved for yourself, and that premature intercourse is likely to get in the way.

The point I would like to stress, with this example, is that in each of these phases the learning must be done by the learners themselves. Anything else is an educational disservice.

3. The Relearning Phase

Relearning is the phase that is most easily recognized as educational. In this phase, we directly empower students by giving them actual practice in the skills of critical thinking and problem-solving. I will illustrate this phase with a college class that wanted to openly acknowledge and support their sexual feelings and needs, but felt that intercourse is an inappropriate dating activity in this day of AIDS. In this phase of the SURE method, the students are seeking an alternative to the belief that intercourse is the only *sufficiently satisfying* sexual activity; unfortunately, this sadly is not a topic that has been familiar to educational settings. There presently is no name for sexual activites that do not include penetration, other that the parallel term, "outercourse." Thus, learners embarking on such virgin territory often need some time to formulate their thoughts before sharing them.

With adequate preparatory time, students become enthusiastic about sharing their responses to sexuality issues and about hearing what others have to say in answer to the same questions. Therefore, fill-in-the-blank worksheets are usually welcome pre-discussion homework. The students, inspired by the prospect that they will be pioneers, most often readily welcome filling in the empty space—left by the previous unlearning phase—with their own thinking.

Filling in a worksheet on outercourse generated the following class discussion and conclusions: 1) Pregnancy is avoided if sperm is kept away from the vulva; 2) STDs may be prevented if lesions, and their exudates, are avoided; and 3) For years, sex therapists have recommended outercourse exercises to increase feelings of comfortability with one's own, and another's, sexuality.

The students argued that outercourse is not inferior, less complete, nor less mature than intercourse. In fact, outercourse may demand greater creativity, communication skills, attention to detail, mutual sensitivity, and responsiveness. Outercourse is much more than a mere substitute for intercourse. It requires more attention and time than intercourse, but it also can be more varied and can alternately excite, inhibit, entice, prolong, tease, and progress to orgasm or not. The students said that they thought it demeaning to call this "foreplay," as outercourse celebrates the concept that getting there is the most fun.

4. The Exercise Phase

The last phase, exercise, is an evaluative phase which assesses the benefits for the larger society. One of the most striking social features in sex education today is the incredible diversity of communities with specific values and needs. Yet,

(Continued on page 23)

Homophobia and Sexuality Education

The Story of the Clinic's Experience in New Hampshire

Chuck Rhoades and Cooper Thompson

On April 11, 1988, the Manchester, New Hampshire *Union Leader* ran an inflammatory front-page story, "Sex Ed Course OK's Sodomy, Not Parents," which began a series of homophobic attacks on the Strafford County Prenatal and Family Planning Clinic in Dover, New Hampshire. These attacks set off a controversy which eventually involved county, state, and federal officials, on the one hand, and the ACLU, NOW, and several other progressive organizations on the other. While the *Union Leader* fueled the controversy with sensationalist stories attacking the curriculum, its author, and the executive director of the clinic, a variety of political leaders and appointees attempted to punish the Clinic for developing the curriculum. Faced with these attacks, the staff and the board of directors of the clinic struggled to hold onto their funding while they continued to provide services to their low and moderate income clients.

Unfortunately, these attacks have not stopped and funding for the health services provided by the clinic is far from secure.

This story began four years ago. In 1984, the Clinic was awarded a small three-year federal grant to develop a program entitled "New Directions for Young Men." The State Bureau of Maternal and Child Health was to administer and monitor the grant. Components of the program included a media campaign to place stories about male reproductive health, workshops on male health and sexuality for area educators, and the development of a reproductive health curriculum for young men and women aged 14–18. Chuck Rhoades, the executive director of the Clinic, was to oversee the project; and Cooper Thompson was hired to write and pilot test the curriculum in 1985.

The Curriculum

The curriculum which resulted from this work, *Mutual Caring–Mutual Sharing*, asks educators to take an affirmative approach to sexuality—to see sexuality as fundamentally healthy and multivariant in terms of its individual expressions. It also asks them to deal with issues such as misogyny and homophobia. Twenty pages of introductory notes to the prospective teacher of this curriculum lay out our approach to the teaching of sexuality; and twenty-five pages are devoted to describing class sessions, which deal with decision-making, birth control, and reproductive function. Rather than having separate sessions devoted to misogyny and homophobia, material on gender roles and sexual orientation is integrated into the sessions through structured activities and suggestions to the teacher about her or his behavior in the classroom. (Because it provoked most of the controversy, the introductory section "Assumptions and biases about Sexual Orientation" has been reproduced and accompanies this article.)

In pilot tests in New Hampshire in 1986, young people told us that they felt challenged by this material but that they also learned a great deal from each other and from us—and felt that the program was clearly worth their time. In workshops for educators across the state, in 1986 and 1987, we were consistently applauded on our approach; other educators asked us for techniques to reduce homophobia in the classroom and for ways to give support to young people who had questions about their sexual orientation. The curriculum was published in late 1987 and, soon thereafter, was nominated by New Hampshire health officials for a national Health Promotion Award. It then appears that a

right-to-life group member, in northern New Hampshire, obtained a copy of the curriculum and sent it to the *Union Leader* and to Senator Gordon Humphrey (R-NH). That was in February, 1988. In April, the attacks on the curriculum began.

The Chronology of Events

April 11: The conservative *Union Leader* ran an article, with the headline "Sex Ed Course OK's Sodomy, Not Parents," and made a series of inaccurate and misleading statements about the curriculum. ("OK's sodomy" is apparently a reference to the following sentence in the introduction: ". . . gay and lesbian adolescents [are] perfectly normal and their sexual attraction to members of the same sex [is] healthy." The word "sodomy" is never used in the curriculum. "Not Parents" is a reference to statements we made in the introduction that it is difficult and perhaps undesirable to get extensive parent involvement in a sexuality education program for older adolescents, beyond written permission for the child's participation. We based this on our experience working with parents and our assumption that a primary developmental task for adolescents is separation from their parents. This information was never given in the newspaper article.)

April 12: Two Strafford county commissioners voted to immediately suspend county funding of more than $39,000 a year for prenatal services and justified their actions on the basis of the affirmative statements in the curriculum regarding lesbian and gay youth. The commissioners stated that funding would be restored only if the Clinic disavowed the curriculum and "its teachings about homosexuality."

April 14: The New Hampshire National Organization of Women publicly supported the Clinic and threatened the county commissioners with a lawsuit; the *Union Leader* editorial for the same day was entitled "Saying Yes to Sodomy."

April 16: Humphrey called for a federal investigation of the Clinic and publicly condemned the curriculum.

April 18: Nabers Cabaniss, a deputy assistant secretary in the Department of Health and Human Services with responsibility for monitoring all family planning funding in the United States, sent a memo to the federal Region I Office to "take whatever action is necessary to suspend any further dissemination of this curriculum."

April 24: The *Union Leader* published an editorial on the curriculum and the Clinic entitled "The Perversion Pushers."

April 29: State and federal officials demanded that, by May 4, all remaining copies of the curriculum held by the Clinic be handed over to them; that the Clinic provide names of all those who had requested and received a copy of the curriculum; and that the Clinic submit a detailed report concerning community review of the curriculum during its development. The Clinic was informed that the nomination for the Health Promotion Award was being withdrawn.

May 2: The Clinic announced that it would submit the report and temporarily stop distribution of the curriculum, but would not hand over the remaining copies nor the names of those who had received copies.

May 11: The county commissioners voted to restore prenatal funding based on a recommendation by the county attorney that their legal position was weak. However, they continued to publicly make statements opposing the affirmative positions on homosexuality in the curriculum.

May 12: The *Union Leader* published stories on clergy reaction to the curriculum; one local member of the clergy called for the death penalty for gays.

May 13: A state official threatened action if the Clinic did not turn over remaining copies of the curriculum, and cited a state claim to ownership of the intellectual property of the curriculum.

During June, July, and August, negotiations were conducted between the state and the Clinic, with the attorneys from the Reproductive Freedom Project of the ACLU representing the Clinic. Negotiations, concerning the future distribution and ownership of the curriculum, were near to settlement when the state and the Clinic received notice on noncompliance with the federal contract under which the curriculum was developed. In a letter from the Region I Office of Health and Human Services (but with authority from Cabaniss), the Clinic was cited for noncompliance on technicalities in the community review process, e.g., no invitations to meetings were sent to the members of the community review committee. The letter also stated that the curriculum could not be used or disseminated by the state or by the Clinic and that certain "post-development costs" (not further specified) were disallowable under the contract, and that an attempt would be made to recover these costs, i.e., the Clinic might be forced to pay back a portion of the contract monies already received.

Meanwhile, back in the Senate, the curriculum was being used by Humphrey to spread his brand of homophobia to all the programs receiving federal funding under the FY 89 Labor, Education and Health and Human Services Appropriations Bill. On July 27, Humphrey introduced an amendment to this bill that would prohibit any federal

(Continued on page 18)

Mutual Caring – Mutual Sharing

(An Excerpt from the Introduction to the Curriculum)

Executive Director's Note: We are running the following pages from *Mutual Caring–Mutual Sharing* to illustrate the institutionalized homophobia that surrounds this controversy. Certainly nothing in these pages deserves the intense time and money the government has spent to withhold this information. We are also printing these pages because we believe that the suggestions in the text bear consideration by educators in planning their programs.

Assumptions and Biases about Sexual Orientation

In the past 15 years, there has been a major shift in the research and psychological theory associated with heterosexuality, bisexuality, and homosexuality. Prior to this time, research and theory concentrated on the problem of homosexuality as deviant behavior and what caused a person to become a homosexual. With an increased understanding of homosexuality, the foci became the problem of homophobia (the negative reactions people have to homosexuality and bisexuality) and what causes sexual orientation. Unfortunately, adolescent sexuality education materials generally haven't caught up with these changes and continue to have a homophobic tone and present homosexuality as a deviant behavior, a "problem" similar to the problems of transvestitism or pedophilia, or at best an "alternative lifestyle." A rare exception is the wonderful book for teens, *Changing Bodies, Changing Lives,* in which equal time is given to same sex and opposite sex partners and in which gay and lesbian teens are as affirmed as heterosexual teens.

We chose to take an affirmative approach to sexual orientation in this curriculum because we, too, believe that the problem is a homophobic culture, not the behaviors of the gays, lesbians, and bisexuals in the culture. Because of this homophobia, lesbians and bisexuals experience an enormous amount of prejudice and discrimination on a daily basis, resulting in a sense of invisibility and vulnerability and high levels of personal pain. This is particularly true for those teens who know at an early age, often before puberty, that they are attracted to members of the same sex and yet experience a culture in which they are told that they are immoral, evil, or sick. They are often rejected by parents and peers and must find the strength in themselves to affirm a personhood which seemingly no one else will.

Homophobia also causes problems for heterosexuals, especially young men, by defining affection and intimacy as interactions between those of opposite sex partners only. This results in distant and non-feeling relationships between those of the same sex. In addition, homophobia reinforces some destructive aspects of traditional sex roles by asserting that "real men" are attracted to women and are to behave in a manly fashion; to be gay or presumed to be gay is cast as being feminized, weak, and less than a man. The gay or gay-identified teen is therefore forced to struggle against a double layer of prejudice involving both his sexual feelings as well as his presumed lack of manliness.

The research on sexual orientation has revealed that most of the popular beliefs concerning the causes of hetero-, bi-, and homosexuality are myths. What emerges from current thought and research in the sexuality field is that orientation appears to be established early in life, probably by age three. The discovery process of one's orientation to same and/or opposite sex occurs later in sexual development processes, from adolescence through adulthood. There is strong evidence to suggest that there is nothing a parent can do to influence orientation one way or another. Orientation appears to be the result of a complex set of factors, so that, ultimately, no one knows why some people are lesbian, gay or heterosexual. What is known is that lesbians and gay men exist in all societies. What changes drastically from society to society is not necessarily the numbers of lesbians and gays and certainly not the presence of lesbians and gays, but the treatment of lesbians and gays.

Because of all the dynamics mentioned above, dealing affirmatively with sexual orientation issues presents a challenge to the sex educator. Even if the sex education materials and the sex educators affirm all sexual orientations and actively suport gay, lesbian, and bisexual

students, the school and community may hold homophobic attitudes. Parents' fears of a teacher "encouraging" homosexuality or bisexuality may make the teaching of a positive, affirming approach difficult, despite the fact that the parents' fears are not supported by the available research.

We personally still have many questions about the best way to handle homophobia in educational settings. But based on our knowledge and experiences at the time of developing and writing this curriculum, we decided to deal with sexual orientation in the following ways:

1. We set a groundrule early on that participants should refer to their sexual partners as "partners" or "sexual partners" rather than as "girlfriend" or "boyfriend." We did this as a way to provide some anonymity to those teens who might have a same sex partner and would feel unable to talk about their experiences in the group. In setting this groundrule, we explained to the group our reasons for doing so. (See related comments about this below.)

2. In role plays, vignettes, or case studies, we always tried to include lesbian, gay, and bisexual characters in addition to heterosexual characters.

3. In discussing birth control methods and risk factors in unplanned pregnancy, we raised the question of why it might be important for gays and lesbians to be informed about methods even though same sex partners may not have to worry about unplanned pregnancy. We talked about risk factors associated with STD's between same sex partners and discussed safer sex practices, especially in the context of AIDS.

4. We were very clear with the teens that some of them or their friends might be gay, lesbian, or bisexual and reminded them that it might be scary for them or their friends when this discovery was made. We made the assertion that gay and lesbian adolescents were perfectly normal and that their sexual attraction to members of the same sex was healthy.

5. We provided information on what is known about the causes of sexual orientation, debunking the popular mythology in the process.

6. We responded appropriately when disparaging comments were made about gays, lesbians, and bisexuals. This included responding to the casual or perjorative use of words such as fag, queer, lezzie, etc.

We did not attempt to develop activities on homosexuality or homophobia per se but tried to bring an affirmative tone and style to the entire curriculum. In a longer program on sexuality, we would have included separate activites. In the appendix to this curriculum are resources for curriculum on homosexuality and homophobia.

As a sexuality educator who deals affirmatively with sexual orientation, you may find that there is some suspicion on the part of participants or sponsors that you are lesbian, gay, or bisexual. These suspicions about you are a reflection of their homophobia. Depending on how strongly they feel this, they may distance themselves from you, discredit you, raise questions about the appropriateness of the program, even try to interfere with the teaching of the program. If this is the case, then we encourage you to consider how to deal with these people's homophobia. Seeking the support of colleagues or the co-leader, if one is available, is certainly a starting point. Remember, the problem is not your sexual orientation or the fact that you are being affirming of gay and lesbian youth; the problem is homophobia. (If you are lesbian, bisexual, or gay, you may well feel the impact of this at a deeper and more personal level. We encourage you to seek support from those you trust and, like the situation faced by heterosexuals, focus on homophobia as the problem.)

How leaders and the participants deal with public declarations of individual sexual orientations is tricky. A basic groundrule for leaders is that they not share information about their own sexual experiences. A ground-rule which may be used with adolescent participants is that they also not share personal sexual information with the group. But part of the impact of cultural homophobia is that gays, lesbians, and bisexuals are sexualized by the culture; understanding the impact of this homophobia forces one to realize that sexual orientation is a separate issue from sexual expression. So a groundrule about sharing of personal sexual material doesn't really deal with the problem presented here.

Heterosexuals have the luxury of being able to share information about the gender of their partners casually, without having to worry about other's negative reactions. Lesbian and gay teens may be particulary confused and/or frightened about others' reactions to their sexual orientation (and they have every right to be) and so will only share this information in very rare circumstances. So it would seem unfair to allow heterosexual participants, or more accurately those participants who believe that they are heterosexual, to state their sexual orientation in light of the experience of the gay or lesbian teen who does not feel safe to share their sexuality orientation. To make matters worse, a teen who believes that they are heterosexual may declare their sexual orientation by a denial that they are gay or lesbian and perhaps make disparaging comments about gays and lesbians in the process.

One way to solve this dilemma is by having a groundrule that no one should state their sexual orientation. However, this could result in a situation of secrecy; the educator may be perceived as saying to the group that it isn't safe to be gay or lesbian and thus there may be even less safety for the gay or lesbian teen during the program.

What the educator might consider doing is setting the groundrule about the term "partner" that we suggested above and fully explaining to the group why that groundrule is in place. Suggest that people who generally consider themselves heterosexual not state their sexual orientation in deference to the experience of gays and lesbians who are often not free to share this information. Hopefully, by having had this discussion, you will have indicated to some of the participants that you are an ally for them while educating some of the other participants about their homophobia.

(Continued from page 15)

funding of programs, curricula, materials, or services that "promote or encourage homosexuality" or use words "stating that homosexuality is 'normal,' 'natural,' or 'healthy.' " Senators Weicker, Kennedy, and Cranston spoke in opposition, but the amendment passed 82-15. Later, the amendment was deleted in the House-Senate Conference Committee, with the wording changed to prohibit the use of federal funds for programs "designed to promote or encourage, directly. . .sexual activity, homosexual or heterosexual."

What Does All This Mean?

As of late August, the negotiations involving the Clinic have not been completed. And even if the Clinic is eventually allowed to distribute the curriculum again—and a token fine is levied—there is justified concern about future funding and the monitoring of any funds that might be granted. State officials have been actively seeking another family planning grantee in the region, but no other organization has agreed to provide family planning services in lieu of the Clinic (a conscious act of solidarity with the Clinic).

Even if funding is continued, those state and federal officials charged with monitoring family planning programs could harass the Clinic well into the future with a variety of petty demands for reports and documentation. In fact, other family planning grantees, around the country, have recently been warned by federal regional health officers that they must be in strict compliance with the regulations regarding community review of materials. It would not be surprising if other grantees had to undergo a detailed investigation of the process they use to screen materials in their programs. Any material, suggesting an affirmative approach to homosexuality, may be suspect and, in effect, censored by the feds. Given the Senate's recent willingness to pass an antihomosexuality amendment, censorship of lesbian and gay affirmative materials could become a stated national policy and not just the reflection of a few bureaucrats' homophobia.

More generally, this controversy has severely stretched the resources of a highly respected community agency which serves 8,400 low and moderate income women and their families. Their health has, in effect, been jeopardized by others' homophobia. (More precisely, *male* homophobia which, ironically, underscores the link between homophobia and misogyny that is made in the curriculum.) While the staff and the board of directors of the Clinic have, at times, been strengthened by this fight, they are clearly tired of battling homophobia and look forward to giving all of their energies to their clients.

The case has also demonstrated, sadly, that there is substantial freedom to be homophobic in this society and little safety being affirmative of lesbian and gay youth and adults. Public officials were never publicly challanged by their colleagues on statements, such as the one made by a county commissioner, "When I was a kid we called them queers," even though a similarly casual statement using the term "nigger" would have drawn criticism from conservatives and liberals alike. Many individuals in the region privately told us of their support for our position, but they felt that they could not do so publicly. Some liberals took issue with our use of the term "normal" and "healthy," and suggested that if we had used less unequivocal terms to describe lesbians and gay men, they could have supported us more easily. Tolerance may be a safer position, but it is a far cry from affirmation.

On the hopeful side, this controversy provided one more opportunity to expose homophobia as a public threat. It provided an opportunity for many people—heterosexual as well as lesbian and gay—to publicly condemn homophobic officals and to support an educational approach, which correctly labels homophobia as the problem and takes an affirmative and inclusive approach to issues of sexual orientation in sexuality education programs.

This controversy has also had a profound impact on both of the authors. There have been times when we have wanted to walk away from this. As heterosexual men, we have come to realize that we have the privilege of being able to live our lives in (relative) peace, without having to deal with the day-to-day homophobia experienced by our lesbian and gay friends and colleagues. But all of this has also strengthened us, and it has reaffirmed that we were heading in the right direction when we began. So Chuck Rhoades remains the executive director of the Clinic, where his priority, at this time, is to insure funding of essential services to its clients. And Cooper Thompson continues his educational work as the national coordinator of the Campaign to End Homophobia. We are determined to find a way to end the censorship of the curriculum and to get it back into distribution; and we are committed to making the connections between sexuality education and homophobia.

Chuck Rhoades has been a sexuality educator for 11 years; Cooper Thompson has been an educator on issues of oppression for the past 10 years.

Editor's Note:
As of September 7, 1988, *Mutual Caring–Mutual Sharing* can be purchased from The Clinic, 50 Chestnut Street, P.O. Box 791, Dover, New Hampshire 03820 for $12.

Conference/Seminar Calendar

"AIDS: A CHALLENGE FOR EDUCATORS," *October 20–21, 1988.* A conference "designed to provide administrators of public and private schools, colleges and universities, principals or their designates, and senior teaching and counselling staff with a comprehensive and practical approach to managing implications of AIDS in the school. Experts from Canada and the United States will facilitate a candid look at the implications of this deadly disease, and will provide participants with the information required to implement sound practices to deal with AIDS in the educational system." Toronto Airport Hilton, Toronto, Ontario, Canada. Contact: Med-Corp, Inc., Occupational Health and Management Consultants, Suite 200-145, Queen Street East, Brampton, Ontario, L6W 3P6, Canada, (416) 452-9111.

BUREAU OF NATIONAL AFFAIRS SEMINAR, "WORK AND FAMILY CONNECTIONS: CHANGING CONFLICT INTO COOPERATION," *October 20–21, 1988.* Twenty-one organizations will contribute to the seminar. The Mayflower Hotel, Washington, DC. Contact: Work and Family Seminar Registrar, BNA Conference, 2445 M Street NW, Suite 275, Washington, DC 20037, 1-800-424-9890 or (202) 452-4420.

SEXUAL ADDICTION SEMINARS, "ADVANCED TRAINING: COUNSELING THE SEXUAL ADDICT," *October 23–27 and December 4-8, 1988.* Sponsored by the Golden Valley Institute for Behavioral Medicine. "Designed to enhance the health care professional's knowledge and treatment of sexual addiction and provide professional materials to assist in the treatment of sexual dependency." Faculty and presenters include Patrick Carnes, PhD, Eli Coleman, PhD, and Ginger Manley. Contact: Sarah Sandberg, Executive Director, Golden Valley Health Center, 4101 Golden Valley Road, Golden Valley, MN 55422, (612) 588-2771 x3300.

3RD NATIONAL FORUM ON AIDS AND HEPATITIS B, "PROTECTING THE HEALTH OF AMERICA'S HEALTHCARE SYSTEM," *November 21–22, 1988.* Sponsored by the National Foundation for Infectious Diseases, organized with the assistance of the American Society for Microbiology, and co-sponsored by 33 organizations. Designed for individuals and organizations who "require the most current information on AIDS and Hepatitis B infection control in the workplace" and who are "responsible for formulating health care protection policies, creating educational programs, implementing management strategies, and developing products to protect health care personnel from blood-borne viruses." Grand Hyatt Hotel, Washington, DC. Contact: 3rd National Forum on AIDS and Hepatitis B, c/o ASM Meetings Department, 1913 Eye Street NW, Washington, DC 20006, (202) 833-9680.

INTERVENTION IN CHILD SEXUAL ABUSE: VICTIMS, OFFENDERS, AND SURVIVORS (seminars), *November 30, December 1, December 2, 1988.* Training with Suzanne M. SGroi, MD, and A. Nicholas Groth, PhD. Hotel Ibis, Disneyland, Anaheim, California. Contact: Dorothy Molis, Forensic Mental Health Associates, 29 Linwood Street, Webster, MA 01570, (503) 943-3581.

AMERICAN COLLEGE OF NURSE-MIDWIVES 34TH ANNUAL CONVENTION, "ONE WORLD... MANY HANDS," *June 4–7, 1989.* Sheraton Harbor Island Hotel, San Diego, California. Contact: Stephanie Jo Kerby, Convention Coordinator, American College of Nurse-Midwives, 1522 K Street NW, Suite 1120, Washington, DC 20005, (202) 347-5545.

THE V INTERNATIONAL CONFERENCE ON AIDS: THE SCIENTIFIC AND SOCIAL CHALLENGE," (24 credit hours), *June 4–9, 1989.* Sponsored by the International Development Research Centre, the Department of National Health and Welfare, Ottawa, Canada, and the World Health Organization, and "sanctioned" by the International AIDS Society. "The AIDS pandemic has brought with it a gradual affirmation of our interdependence as countries, communities, governments, biomedical and social scientists, and individuals. Achieving the partnership which must emerge as a response to our mutual needs is the overall goal for this, the V International Conference on AIDS." The conference will "provide a forum for bringing together the knowledge, the views and the perspectives of biomedical and social scientists, public policymakers and community-based AIDS organizations." Focal areas will be epidemiology and public health; clinical aspects of AIDS; research; AIDS and the individual; AIDS, society and behavior; ethics and law; international issues; and the economic impact of AIDS. Palais des Congrès, Montreal, Quebec, Canada. Contact: V International Conference on AIDS, Secretariat Kenness Canada Inc., 1010 St. Catherine Street West, Suite 628, Montreal, Quebec, Canada H3B 1G7, (514) 874-4006.

(Continued from page 11)

12. Cates, Jr., W. Abortions for teenagers. In J.E. Hodgson (ed.), Abortion and sterilization: Medical and social aspects. London: Academic Press, 1981, 139-154.
13. Adler, N.E. & Dolcini, P. Psychological issues in abortion for adolescents. In G.B. Melton (ed.), Adolescent abortion: Psychological and legal issues. Lincoln: University of Nebraska Press, 1986, 74-95.
14. Brody, J. Personal health. *The New York Times*, April 30, 1986, C12.

Susan N. Wilson, MSEd, is the executive coordinator of the New Jersey Network for Family Life Education, Center for Community Education, Rutgers University School of Social Work. Catherine A. Sanderson is a junior, majoring in psychology at Stanford University, where she has also worked as a counselor in a health information center. During the summer of 1986 and 1987, Sanderson assisted with the research for the 1988–1989 edition of Contraceptive Technology *with Professor James Trussell at Princeton University. During this past summer, she worked with the New Jersey Network for Family Life Education, researching articles on child sexual abuse and AIDS knowledge among adolescents, and assisting with AIDS prevention teacher training.*

News . . .

What About the Boys?

According to Karen J. Pittman, director of the Adolescent Prevention Policy Division of the Children's Defense Fund (CDF), a major reason teenage pregnancy prevention programs are not more effective is because instructors, counselors, and other service providers often do not seem to understand that when it comes to sex boys and girls are different. Co-educational sexuality programs, she said, are typically packaged for adolescent women rather than males, despite research suggesting girls already know more about sex than boys. Therefore, educational efforts may be unconsciously reflecting and even reinforcing society's double standard of sexual behavior which holds that boys who impregnate unintentionally are—at least—unwise. "Programs," Pittman said, "should be packaged differently to reach young men."

A new report from CDF, *What About the Boys: Teenage Pregnancy Prevention Strategies,* is the latest in the Adolescent Pregnancy Prevention Clearinghouse series. (A companion report, *Adolescent and Young Adult Fathers: Problems and Solutions,* was published earlier in May.) The new report contains descriptions of 27 programs that address young males' needs for sexuality-specific information, counseling, and services—drawn from a CDF-convened meeting of "sex researchers and program experts with long-standing insight into the problems facing young males." It also considers a number of important studies reflecting on adolescent sexuality attitudes and practices. The report gives special attention to: gender differences in adolescent attitudes and behavior; how the ability to escape parenthood responsibilities affects a boy's motivation to be sexually responsible; and how new insight into male-specific sexuality can lead to more effective teen pregnancy prevention programs.

The report states that adolescent attitudes tend to reflect societal attitudes: "Society promotes a double standard of sexual behavior—what is considered appropriate sexual behavior for males is something quite different for females. Despite increased awareness of its pervasiveness and impact, that double standard continues to stand as one of the most serious threats to efforts to help teens delay sexual activity and pregnancy. Boys are expected to perform, to compete, and to seek sexual gratification. They often are taught to associate intercourse with manhood. . . .Girls, on the other hand, are expected to be loving, supportive, and nurturing. They are cautioned that marriage (or at a minimum, love) is a prerequisite for sexual intercourse."

According to the report, attitudinal differences appear to be ingrained by the first experience with intercourse (age 15.7 years for boys, 16.2 years for girls). "Although they have equal levels of anxiety about first intercourse, girls are likely to be worried about whether they are doing the right thing, while boys are worried about whether they are doing the thing right."

The report also emphasizes that the ability of teenage boys to escape responsibilities has increased significantly in recent years, as two-thirds of unmarried teenage mothers are either unwilling or unable to list the father's names on birth certificates.

The report states that three attitudinal differences stand out and have important implications for pregnancy prevention. "First, for both physiological and societal reasons, the connections between sexual activity, pregnancy, and parenthood are weaker for boys than for girls. Second, societal response to unintended pregnancy for boys is much less critical and stigmatizing than it is for girls. Third, societal definitions of responsible parenthood link responsibility to financial support for boys and to nurturing for girls, making it difficult for young men who do not have jobs or employment prospects to see themselves as 'responsible' parents either now or in the future."

When discussing sexual activity and parenthood, the traditional message to adolescents to "wait until you are better off" makes little sense to an increasing segment of the population with diminishing prospects for economic security, the report states. They take such advice as meaning, "don't ever have children." The report also confirms that adolescents with the most limited life options, including recreation, education and employment, are the most likely to become teenage parents.

The report cites innovative sexuality programs—that take 'whole adolescent' approaches including job counseling—as offering the most promise for success in reaching young males. "Given the societal emphasis on the father as provider, it is not surprising to hear some experts argue that, in many ways, improving young males' life options should be the first line of defense against teenage pregnancy." The fact that boys express more desire for access to sexuality information and counseling than do girls, yet girls have a better understanding of sexuality than do boys also suggests a need for greater emphasis on male sexuality in counseling and other services.

In conclusion: "As communities respond to the calls for increased male involvement in preventing unintended adolescent pregnancies with proposals for new or expanded pregnancy prevention strategies, it is essential that any proposed strategies be built solidly on facts, not misconceptions, about young males' attitudes and behaviors and about what young people need to improve their ability to avoid early sexual activity and pregnancy."

WORLDAIDSDAY

"1988 shall be a year of communication and cooperation about AIDS in which we shall:

- *open fully the channels of communication in each society so as to inform and educate more wisely, broadly, and intensively;*
- *strengthen the exchange of information and education and experience among all countries; and*
- *forge, through information and education and social leadership, a spirit of social tolerance."*

The London Declaration of the World Summit of Ministers of Health Programmes for AIDS Prevention, London 26–28 January, 1988.

The World Health Organization has unveiled plans for WORLDAIDSDAY: December 1, 1988. The announcement came in the form of a call for ministers of health to proclaim WORLDAIDSDAY in individual countries. The theme of the day will be: "Tell the World What You're Doing About AIDS."

"We want countries, organizations, and individuals involved in the fight against AIDS to know they're not alone" said Jonathan Mann, Director of WHO's Global Programme on AIDS. "We want everyone to see that there is truly a worldwide effort underway and to see just how broad and wide the global effort has become in just a few years."

An official symbol, action kits with suggested activities, fact sheets, and WORLDAIDSDAY stationery are some of the materials WHO plans to make available to participants. In addition, the first WORLDAIDSDAY Newsletter debuted September 1, 1988.

The objectives of WORLDAIDSDAY are:

- To tell people everywhere that AIDS can be stopped worldwide;
- To convince people that their responsible behavior can protect them and stop the spread of AIDS;
- To encourage compassion and understanding toward those who have AIDS or are infected with the virus;
- To highlight the extraordinary range and scope of the fight against AIDS—all over the world;
- To support AIDS prevention and control programs everywhere.

WORLDAIDSDAY was announced by WHO Director-General, Dr. Halfdan Mahler, in the spirit of the London Declaration, following the historic AIDS Summit of Ministers of Health in January 1988.

New Report Shows Weakness of Abortion As an Election Issue

The Alan Guttmacher Institute (AGI) recently announced that analyses of federal election results, from 1974 to 1986, convincingly demonstrate that abortion has had little or no influence on the outcome of the vast majority of races, and that the widespread perception that support for abortion is inherently politically dangerous is false. Contrary to popular belief, they said, antiabortion groups have not—as they have claimed—been successful in sabotaging the election prospects of politicians who refuse to support their agenda. Moreover, when given a chance

to vote directly on proposals to prohibit or restrict access to abortion through ballot initiatives or referenda in seven states and three cities across the country, the voters have disavowed the antiabortion position on all but one occasion.

These are the major conclusions of AGI's new report, "When the Conventional Wisdom Is Wrong: A Reexamination of the Role of Abortion As an Issue in Federal Elections, 1974-1986" by Patricia Donovan, associate for law and public policy with The Alan Guttmacher Institute. The report, recently issued by the Institute's Washington, D.C. public policy office, charts the rise of abortion as a national political issue following the 1973 Supreme Court decision in *Roe v. Wade,* and documents the role that abortion has, or more often has *not,* played in federal elections since that time.

The report notes that public opinion solidified in favor of legal abortion *before* 1973 and has not wavered for the past 15 years, despite efforts by the antiabortion movement—and the active support of President Reagan—to overturn the Supreme Court decision and make abortion illegal. Furthermore, it documents that support for abortion does not divide along partisan lines nor does it break down along racial or religious lines. Most Republicans and most Democrats support legal abortion, as do most Catholics, despite their church's strong opposition to abortion.

The report suggests that the misperception that Democrats are prochoice and that Republicans are antiabortion is based mainly on the fact that, since 1976, the Republican Party platform has supported a constitutional amendment prohibiting abortion while the Democratic platform has supported a woman's right to choose. It points out, however, that according to a 1987 national survey, nearly six in ten Republican voters oppose a constitutional amendment prohibiting abortion, with the proportion among Democratic voters only slightly higher. Moreover, the report notes: "the Republican Party's abortion position does not reflect the views of. . . even delegates to its own conventions. Only 28% of the delegates to the 1980 Republican convention favored an antiabortion constitutional amendment, even though the party's platform and Ronald Reagan strongly backed one."

The analyses also demonstrate that political support for abortion cuts across religious and racial lines. Despite the widespread perception that Blacks are antiabortion, the report points out that nearly all Black members of Congress have been strong prochoice advocates, and public opinion polls have indicated that a majority of Blacks oppose the prohibition of abortion. Similarly, despite the Catholic Church's strong opposition to abortion, Catholics do not differ significantly from other Americans in their stand on the issue. For example, according to a *New York Times*/CBS survey, nearly two-thirds of all Catholics feel that "the right of a woman to have an abortion should be left entirely to the woman and her doctors."

Even so, the perception that support for legal abortion was politically risky was solidified, according to the report, soon after the 1973 decision due, in large part, to the immediate and unprecedented political visibility of the Catholic hierarchy on the issue, and later, to the perceived rise to political prominence of the evangelical Christian "New Right." The report points out that this misperception went largely unchallenged by the media, which tended to portray the antiabortion movement as a major political force, regardless of evidence from public opinion polls, election analyses, and antiabortion referenda results indicating otherwise.

According to the analyses, however, in recent years it appears that this deeply entrenched political perception about abortion on Capitol Hill and in the media is slowly beginning to change.

The report documents a number of occasions on which Congress has defied antiabortion activists' threats of presumed retaliation at the polls—the most recent was the vote on Judge Bork's confirmation to the Supreme Court. National Right To Life Committee President John Wilke proclaimed this "the most crucial prolife vote in 14 years," and warned that "this is one vote where no prolifer will accept any reason or any excuse from a senator who opposes Judge Bork." Yet 58 senators, including the 18 up for reelection in 1988, voted against Judge Bork's Supreme Court nomination. Another indication of changing perceptions, according to the analyses, is the fact that several highly visible politicians in recent years have either modified or fatally reversed earlier antiabortion positions in preparation for statewide or national campaigns.

Despite these changes in perception and Congress' unwillingness to reverse the legality of abortion, the report points out that Congress still tries to appease the right to life movement, in every other way, by condoning, or at least tolerating, right to life assaults on an increasingly wide range of issues that until recently were regarded as peripheral or even unrelated to the antiabortion cause.

President of The Alan Guttmacher Institute, Jeannie Rosoff, in commenting on the findings of the report, said: "There are serious and far-reaching consequences of Congress' perceived need to bow to right to life pressure at every turn—consequences not generally well understood by the American people. Women in the United States, and in developing countries, have had their access to family planning services conditioned on their ignorance of abortion, as a result of right to life agitation. Research into new methods of contraception has been stalled and new methods available in other countries may never come to the market in the United States, due to the antiabortion intimidation of drug companies."

A SIECUS UPDATE

From Debra W. Haffner, Executive Director

Twenty five years ago this fall, a small group of diverse professionals were working diligently to lay the foundation for a new national organization. The purpose was to provide a national forum to establish sexuality as a health entity. Their work came to fruition on April 29, 1964, as the Sex Information and Education Council of the United States received its charter in the State of Delaware.

Today as we begin plans for SIECUS' 25th anniversary, we are struck by how far we have come. Sex education is now formally mandated in 13 states, and supported by dozens of mainstream organizations. It is well recognized that medical and public health professionals should receive training in human sexuality. Contraception is readily available to most Americans, abortion is legal, homosexuality is no longer considered a mental illness, and in many communities, condoms are sold at the checkout counters of supermarkets and convenience stores. Both men and women are encouraged to lead fulfilling professional and personal lives. Consumer magazines regularly feature articles on all aspects of sexuality, and radio and television talk shows, dealing with sexual issues, proliferate. 1988 is very different than 1964.

And yet how far we still have to go. Sexuality education continues to be surrounded by controversy. The media and advertisements continue to bombard us with sexually exploitive messages. A double standard still rages in our schools, and women continue to earn significantly less than men in comparable jobs. Negative consequences of sexual behavior persist: half of the babies born in America are unplanned; teenagers have a million pregnancies a year; the sexual abuse of children continues; sexually transmitted disease rates are increasing; and the AIDS epidemic is changing the way we view our sexuality. Eight years of the Reagan administration have seen a return to sex discrimination, institutionalized homophobia, and continual attacks on our sexual rights.

During the past 25 years, SIECUS has played a leadership role in providing sexuality information and advocating the sexual rights of all people. SIECUS continues to affirm sexuality as a natural and healthy part of living. SIECUS collects, develops, and disseminates information and educational materials, promotes communication about sexuality, and advocates for comprehensive, high quality sexuality education.

SIECUS houses the leading sexuality education library in the country. Our dedicated staff provide technical assistance, training resources, and information to thousands of professionals and individuals each year. Over 2000 members form a SIECUS network across the country.

We are very excited about our plans for the coming year. We expect to increase membership services, issue new publications, build a new program department, convene a national meeting on sex education, and release a major report, "Sex Education 2000." As always, we will continue to be in the forefront of advocating the need for sexuality education and information for people of all ages. We welcome your continued support.

(Continued from page 13)

many sex educators hesitate at the point of getting specific and their ideals are not broken down into usable models, much less role-models, that can be incorporated into or illustrated by our daily lives. Often no flesh is put on the bones of our paradigms and the public, left on its own to decipher what we mean by a "sex positive" paradigm, for example, is not really sure of what we are trying to say.

Moreover, people fear for the values specific to their community when we leave them unspecified. I think this may be why many people are confused and ambivalent, and certainly divided, in their support of sex education. Can respect come without understanding? Can understanding come without examples? Can we touch people with our messages if we avoid their daily lives?

If getting down to specifics is risky business for sex education, then why not call it "art," adopt pseudonyms, and get on with it. Let us write plays and novels and create films, videos, and other artwork to illustrate what we really mean by sex-positive health in daily life—with specific, life-enhancing, relevant, and practical sex-positive messages that can actually be lived.

Reference

calderwood, d. Educating the educators. In L. Brown, (ed.), Sex education in the eighties: The challenge of healthy sexual evolution. New York and London: Plenum Press, 1981, 191-201.

David McAllister, MA, recently received an award from the New York City Department of Health for his outstanding 20-year contribution to the Department. He teaches human sexuality within the City University of New York system, trains teachers and principals for the New York City School Board in sexuality education, and speaks at many conferences and workshops. He is a doctoral candidate in the human sexuality program of New York University.

AIDS AND SAFER SEX EDUCATION

An Annotated SIECUS Bibliography of Available Print and Audiovisual Materials

Since the first SIECUS bilbiography on AIDS and safer sex education, there has been a veritable explosion in materials on AIDS. This bibliography contains a wide range of materials for different audiences. The citations, which are listed without evaluation, include books, curricula, and audiovisuals for AIDS and safer sex education.

Many of the publishers and distributors listed below have other materials on AIDS not specifically related to education, prevention, and safer sex. Many also will continue, no doubt, to make available new resources on AIDS. You may, therefore, wish to request their complete publication lists or catalogs and to ask to be placed on their mailing lists for new publications.

Please note that, other than its own publications, SIECUS does not sell or distribute any of these publications. Most of the print materials are available for use, however, at SIECUS' Mary S. Calderone Library, New York University, 32 Washington Place, Room 52, New York, NY 10003; 212/673-3850.

Single copies of this bibliography are available from SIECUS on receipt of payment and a stamped, self-addressed, business-size envelope. In bulk, they are $2.50 each for 5-49 copies and $1.50 each for 50 copies or more. Please add 15% to cover postage and handling (p/h).

This bibliography was compiled by Laura Berman, with assistance from SIECUS staff.

BOOKS

General Public

AIDS: FACTS AND ISSUES
Victor Gong, ed.

The editor and 19 other contributors to this book—which has been written for the general public—draw from a wide range of experience in medicine, epidemiology, nursing, psychology, immunology, microbiology, social work, and activism in the gay community. The book was originally published in 1985 under the title *UNDERSTANDING AIDS.* (1986 rev., 388 pp.; $25.00 hard cover, $10.95 paper.)

Rutgers University Press, 30 College Avenue, New Brunswick, NJ 08903; 201/932-7762.

AIDS: PERSONAL STORIES IN PERSONAL PERSPECTIVE
Earl E. Shelp, et al.

Provides information about AIDS, its effect on both patients and nonpatients, the response of society, and the obligation of the church. (1986, 204 pp.; $7.95.)

Pilgrim Press, 131 West 31 Street, New York, NY 10001; 212/594-8555.

AIDS: YOU CAN'T CATCH IT HOLDING HANDS
Niki de Saint Phalle

A colorful picture book, done in crayon and felt-tip pen, that presents the facts about AIDS in an unmenacing way. The artist worked in collaboration with Swiss immunologist, Dr. Silvo Barandun, to insure accuracy. The drawings illustrate how one cannot catch AIDS, safer sex techniques, and the ways in which young people are at risk of HIV infection. (1987, 52 pp.; $6.95.)

Lapis Press, 1850 Union Street, Suite 466, San Francisco, CA, 94123; 415/922-4600.

AIDS FACTS
Sandee Boese and Ellis Bowman, editors/publishers

This magazine-style booklet is intended for junior and senior high school students and members of employee assistance programs, health care organizations, governments and military agencies, and their families. It includes medical and scientific data, a variety of high-interest articles and reports, and color graphics and photographs. (1988, 33 pp.; 1-49 copies, prepaid, $3.50; 50 copies or more, $1.75, AIDS Facts Instructor's Guide, $10, add 10% p/h.)

Classroom Connections, Inc., P.O. Box 2208, Merced, CA 95344; 916/444-6009.

AIDS IN THE MIND OF AMERICA
Dennis Altman

This book provides an analysis of how the AIDS epidemic is altering our attitudes toward sex, disease, death, medicine, and politics, in both America and abroad. The book examines reactions to AIDS and its far-reaching ramifications. (1986, 216 pp.; $16.95.)

Anchor Press/Doubleday, P.O. Box 5071, Des Plaines, IL 60017-5071; 516/873-4561.

AND THE BAND PLAYED ON: POLITICS, PEOPLE AND THE AIDS EPIDEMIC
Randy Shilts

By the time America woke up to the dangers of the AIDS epidemic, the disease had spread to every corner of the nation. Although not without factual errors, this book will astound and enrage. (1987, 630 pp.; $24.95.)

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.

BORROWED TIME: AN AIDS MEMOIR
Paul Monett

The love story of two men battling AIDS together. *Newsweek* called it, "A powerful account of shattering eloquence." (1988, 352 pp.; $18.95.)

Harcourt Brace Jovanovich, 111 Fifth Avenue, New York, NY 10003; 212/614-3000 or 1-800-346-8648.

EPIDEMIC OF COURAGE: FACING AIDS IN AMERICA
Lon G. Nungesser

The author, who himself has AIDS, talks with seven people with AIDS about the impact the disease has on their lives. He goes on to talk with a lover, a mother, a brother, a health care provider, and a friend about the crises they have suffered while working with and loving people with AIDS. (1986, 255 pp.; $7.95.)

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.

SEX, DRUGS AND AIDS
Oralee Wachter

Based on the film, *SEX, DRUGS AND AIDS,* which is directed toward teenagers, this book dispels the myths of how the virus is transmitted and provides young people with ways to safeguard themselves. Although written for teenagers, it is an excellent introductory book for anyone concerned about AIDS. (1987, 76 pp.; $3.95.)

Bantam Books, 665 Fifth Avenue, New York, NY 10022; 212/765-6500.

THE SCREAMING ROOM
Barbara Peabody

A mother's journal of her son's struggle with AIDS. A true story of love, dedication, and courage, told with directness and feeling. (1986, 254 pp.; $3.95.)

Oak Tree Publications, Inc., 3870 Murphy Canyon Road, Suite 203, San Diego, CA 92123; 619/560-5163.

SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME
C. Everett Koop, Surgeon General of the United States

This booklet provides information about AIDS, how it is transmitted, the relative risks of infection, and how it can be prevented. (1986, 36 pp.; free.)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Division of Maternal and Child Health, Rockville, MD 20857; 301/443-2330.

YOU CAN DO SOMETHING ABOUT AIDS
Sasha Alyson, ed.

A free book, from the publishing community, for the millions of Americans whose energy and compassion will win the battle against AIDS. (1988, 126 pp.; free.)

The Stop AIDS Project, Inc., 40 Plympton Street, Boston, MA 02118; 617/542-5679.

CURRICULA

Elementary Level

THE KIDS ON THE BLOCK

This program on AIDS prevention is designed to complement an existing program on sex education and/or family life education for grades five and up. It is available for demonstration programs at national conferences. (1988, $1475 for puppets, scripts, props and follow-up activities, plus $750 for one-day training for up to 25 teachers or dramatic actors.)

The Kids on the Block, Inc., 9385-C Gerwig Lane, Columbia, MD 21406; 301/290-9095 or 1-800-368-KIDS.

SEE SPOT, SEE SPOT RUN . . . FROM AIDS
Ric Loya

Sixteen lesson plans, developed by teachers for teaching about AIDS, are assembled in this 100-page resource publication. Lessons are provided for grades kindergarten through sixth. (1987, $13.40.)

National Association of Teachers of Comprehensive Health Education, 6020 Miles Avenue, Hunt Park, CA 90255; 212/582-4550.

TERRY THE FRIENDLY DRAGON HELPS YOU TO BE AIDS SMART

This booklet for students, K-3, describes the immune system as a suit of armor, outlines how AIDS cannot be caught, and describes ways to help protect the immune system. The booklet uses map puzzles and picture-find activities. (1988, 15 pp.; 50 activity booklets (minimum), $37.50; bulk rates available. A curriculum (not available for preview) accompanies the booklet.

Creative Graphics, P.O. Box 381, Mount Vernon, OH 43050; 614/392-4327.

WHAT KIDS NEED TO KNOW . . . ABOUT AIDS

This curriculum integrates AIDS education into life skills for elementary school children. It is divided by grade level and between AIDS and life skill exercises. It provides information and activities for students as well as a section on staff training. It will need to be supplemented with additional information. (1987, 141 pp.; $15.)

Planned Parenthood of North East Pennsylvania, 112 North 13th Street, Allentown, PA 18102; 215/439-8008.

Middle School/High School

AIDS: LEARN FOR YOUR LIFE
Linda Langs and Faye Howard Winters

This package consists of a curriculum of lesson plans and a 25-minute video. Aimed at high school students, these materials give information on what AIDS is, how the virus is transmitted, and how to prevent its transmission. There is flexibility in the curriculum for stressing abstinence and/or condom usage. (1987, 52 pp.; $350; discounts for bulk orders.)

All Media Productions, Educational Division, 1424 Lake Drive SE, P.O. Box K, Grand Rapids, MI 49501; 616/459-9703.

AIDS: THE PREVENTABLE EPIDEMIC
Claudia L. Webster

This teacher's guide presents three lesson plans for teaching about AIDS in grades 9-12. It is designed to be part of the communicable diseases unit of a health curriculum. A video of the same title is intended to be used with the teacher's guide. (1987, teacher's guide, 25 pp.; $6.00 in Oregon, $10.00 out of state; video $30.00.)

AIDS Education Program, Oregon State Health Division, P.O. Box 231, Portland, OR 97207.

AIDS: WHAT YOU AND YOUR FRIENDS NEED TO KNOW
Seattle-King County Department of Public Health

A lesson plan on AIDS designed to help high school students make more informed decisions about risk-taking behavior. Includes slides that accompany the lessons. (1987, 24 pp.; $15.)

Seattle-King County Department of Public Health, 116 Summit Avenue, Suite 200, Seattle, WA 98101; 206/587-4999.

AIDS: WHAT YOUNG ADULTS SHOULD KNOW
William L. Yarber

The instructor's manual presents goals for AIDS education and a three-session lesson plan. It also outlines eight learning opportunities to reinforce the personal health behaviors and attitudes emphasized by the student's guide. Includes test questions, and student handouts and worksheets. (1987, instructor's guide; 44 pp.; $8.95 + p/h; student guide, 20 pp.; prices vary from $2.50 to $1/copy depending on quantity ordered.)

American Alliance for Health, Physical Education, Recreation and Dance, 900 Association Drive, Reston, Va 22091; 703/476-3400.

EDUCATOR'S GUIDE TO AIDS AND OTHER STDS
Stephen R. Sroka

This guide for middle and senior high school teachers provides lessons on AIDS and other STDs. Includes a pre/post questionnaire for students, worksheets, glossaries, and background information. (1987, 91 pp.; $25.)

Stephen R. Sroka Inc., 1284 Manor Park, Lakewook OH 44107; 216/521-1766.

MEDICAL, PSYCHOLOGICAL, AND SOCIAL IMPLICATIONS OF AIDS: A CURRICULUM FOR YOUNG ADULTS
Ralph C. Johnston

This curriculum, designed for late high school and college courses in health or social studies, consists of eight two-hour lessons. Covers topics such as the basic facts about AIDS, AIDS in the human context, AIDS and sexuality, and the ethics of AIDS. (1987, 150 pp.; $25)

State University of New York AIDS Education Project, SAHP, HSC–L2-042, Stony Brook, NY 11794; 516/444-3242.

TEACHING AIDS: A RESOURCE GUIDE ON ACQUIRED IMMUNE DEFICIENCY SYNDROME
Marcia Quackenbush and Pamela Sargent

This newly revised resource guide assists teachers in integrating AIDS information into existing courses. Includes lesson plans which cover the medical, social, and legal aspects of AIDS, and provides worksheets, trouble-shooting tips, and a resource listing. (1988, 159 pp.; $19.95 + 15% p/h.)

Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/438-4080.

Adults

AIDS IN THE WORKPLACE PACKAGE

A comprehensive multimedia educational program, suitable for any workplace, which includes:

1. A 23-minute video, *An Epidemic of Fear: AIDS in the Workplace.*
2. A 68-page *Educational Guide for Managers.*
3. A 53-page *Strategy Manual* and an *Appendix,* which provide suggestions for developing policies and guidelines for responding to AIDS in the work environment.
4. Several brochures (five copies each) including ***AIDS in the Workplace: A Guide for Employers.***

(1986; total package, $398; strategy manual and appendix, $60; video, $275; leader's guide, $65.)

San Francisco AIDS Foundation, P.O. Box 6182, San Francisco, CA 94103; 415/864-4376.

SAFER SEX PRINT MATERIALS

THE COMPLETE GUIDE TO SAFE SEX
Institute for Advanced Study of Human Sexuality
Ted McIlvenna, ed.

This book presents a review of the current information available on AIDS and suggests many avenues for sexual expression which minimize or eliminate HIV transmission risks. (1987, 217 pp.; prices vary from $6.95 to $3.50, each depending on quantity ordered, plus p/h.)

Exodus Trust AIDS Project, P.O. Box 2152, Akron, OH 44308-2152.

CONDOM: WHAT IT IS FOR, HOW IT WORKS

Provides information on the historical development of the condom; how to use and care for condoms; the pros and cons of using condoms; condoms and vaginal contraceptives; choosing and buying condoms; and persuading your partner to use a condom. Includes a sample script for safer sex and a glossary. (1988, 11 pp.; $.75 for single copy, bulk rates available.)

Planned Parenthood Federation of America, Marketing Department, 810 Seventh Avenue, New York, NY 10019; 212/603-4656.

CONDOMS ARE SAFES
Don Arioli and Catherine Blake

Frank and explicit cartoon characters, Jimmy Penis and Vicky Vulva, attempt to encourage condom use. The characters illustrate how to use condoms properly. (1987, 32 pp.; $1.95 U.S., $2.95 Canada + $2 p/h, bulk rates available.)

The Fay Institute of Human Relations Inc., P.O. Box 5p, CDN, Montreal, Canada H3S 2S4; 514/737-1394.

FACILITATOR'S GUIDE TO EROTICIZING SAFER SEX: A PSYCHOEDUCATIONAL WORKSHOP APPROACH TO SAFER SEX EDUCATION
Luis Palacios-Jimenez and Michael Shernoff

This manual provides information on facilitating workshops for gay and bisexual men

on adopting safer sex guidelines. Can be adapted for use by other groups. (1986, 33 pp.; $8.00.)

Gay Men's Health Crisis, Education Department, Box 274, 132 West 24th Street, New York, NY 10011; 212/807-7517.

PLAY SAFE: HOW TO AVOID GETTING SEXUALLY TRANSMITTED DISEASES
Bea Mandel and Byron Mandel

This book uses a question-and-answer format to convey information about what STDs are, how they are and are not transmitted, how they are prevented, communication with a partner about STDs, and what to do if you think you have a STD. (1986, 98 pp.; $4.95.)

Center for Health Information, P.O. Box 4636, Foster City, CA 94404; 415/345-6669.

SAFE SEX GUIDELINES FOR WOMEN AT RISK OF AIDS TRANSMISSION

This sexually explicit fact sheet lists safe and unsafe activities and presents information on the use of condoms, spermicides, latex gloves and barriers. (1986, 2 pp.; $.10 each.)

San Francisco AIDS Foundation, P.O. Box 6192, San Francisco, CA 94103; 415/864-4376.

SAFE SEX IN A DANGEROUS WORLD: UNDERSTANDING AND COPING WITH THE THREAT OF AIDS
Art Ulene, MD

Rather than emphasizing "safe sex," Ulene feels one should concentrate on "safe partners"—those uninfected persons with whom one can be safe and free. Useful for junior/senior high school and college students. Parents will also find the book helpful. (1987, 108 pp.; $3.95.)

Vintage Books, 201 East 50th Street, New York, NY 10022; 212/751-2600.

SAFE SEX IN THE AGE OF AIDS
Ted McIlvenna

Prepared by a sexologist at the Institute for Advanced Study of Human Sexuality, this book answers the questions of today's sexually liberated adults in a fully candid, positive way. (1986, 88 pp.; $3.95.)

Citadel Press, 120 Enterprise Avenue, Secaucus, New Jersey 07094; 201/866-4199.

LEADER RESOURCES

AIDS: A PUBLIC HEALTH CHALLENGE—STATE ISSUES, POLICIES AND PROGRAMS
Intergovernmental Health Policy Project

A collection of information directed toward policymakers. Volume I assesses the problem, with sections on administration/organization, screening/testing, surveillance, confidentiality, and the potential for discrimination. Volume II addresses management and financing, service programs, medical care, support services, education, and research. Volume III is a resource guide. (1987, three volumes, 500 pp.; $80.)

Intergovernmental Health Policy Project, The George Washington University, 2011 I Street NW, Suite 200, Washington, DC 20006; 202/872-1445.

AIDS: PUBLIC POLICY DIMENSIONS
John Griggs, ed.

Based on the proceedings of a national conference sponsored by the United Hospital Fund and the Institute for Health Policy Studies. The book is divided into seven sections: AIDS and Health Policy; The Politics of AIDS; AIDS and Schools; AIDS and the Blood Supply; Acute Medical Services: Four Case Studies; Community Care Services; and Financial Perspectives of AIDS. (1987, 308 pp.; $30.)

United Hospital Fund, 55 Fifth Avenue, New York, NY 10003; 212/645-2500.

AIDS AND ADOLESCENTS: THE TIME FOR PREVENTION IS NOW
Debra W. Haffner

This is the conference report from the first national meeting on AIDS and Adolescents, convened by the Center for Population Options in April, 1987. Written to help program planners, educators, and policymakers design effective AIDS prevention programs for teenagers. (1987, 24 pp.; $10.)

Center For Population Options, 1012 14th Street NW, Washington, DC 20005; 202/347-5700.

AIDS AND THE PUBLIC SCHOOLS
Susan Hooper and
Gwendolyn Gregory

The primary objective of this report is to provide school leaders with medical information about AIDS; with information about the legal implications of AIDS in the school setting; and with an overview of school board policy responses to AIDS taken by school districts across the nation. The report also provides information on developing an AIDS policy and an AIDS curriculum. (1986, 55 pp., $15.)

Research and Information Services Department, NASBA, 1680 Duke Street, Alexandria, VA 22314.

AIDS EDUCATION: CURRICULUM AND HEALTH POLICY
William L. Yarber

This informative publication includes an AIDS knowledge self-test and provides information on teaching about AIDS education; school health policies for persons with AIDS; selected resources for AIDS education and health policy; and an AIDS summary sheet. (1987, 58 pp.; $.90 each copy, with liberal discounts on bulk purchases.)

Phi Delta Kappa, 8th Street and Union Avenue, Box 789, Bloomington, IN 47402; 812/339-1156.

AIDS/HIV EXPERIMENTAL TREATMENT DIRECTORY

A directory of experimental treatments and drug trials for AIDS and related illnesses, prepared with the technical assistance of the Professional Outreach Program of The National Institute of Allergy and Infectious Diseases. Includes a bibliography of treatment; review articles; a list of treatment evaluation units; a map showing the location of treatment trials; an index of physician investigators, manufacturers, and developers; and regional hemophilia coordinating centers. (1988, Vol. I, revised and expanded, 89 pp., supplement, January 1988, 15 pp., Vol. II, May 1988, 118 pp.; $30 for one-year subscription, $15 for individual copy.)

American Foundation for AIDS Research, AmFAR Treatment Directory, 40 West 57th Street, Suite 406, New York, NY 10019-4001; 212/333-3118.

AIDS ON THE COLLEGE CAMPUS
Richard P. Keeling, MD, ed.

This book presents information and guidelines to assist campuses with their educational programs and policy development. It consists of a series of separate statements which address specific issues related to AIDS as college health care providers, students, and student services personnel officers see them. (1986, 86 pp.; $7.50.)

American College Health Association, 15879 Crabbs Branch Way, Rockville, MD 20855; 301/963-1100.

CONFRONTING AIDS: UPDATE 88
Institute of Medicine, National Academy of Sciences

This compendium updates the October 1986 Institute of Medicine report, CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH. The two books together provide definitive information on what we now know about HIV Infection and its epidemiology, education, care of people infected with HIV, drugs, and the international aspects of the AIDS epidemic. (1988, $15.95.)

National Academy Press, 2101 Constitution Avenue NW, Washington, DC 20418; 202/334-2665.

CRITERIA FOR EVALUATING A CURRICULUM
National Coalition of Advocates for Students

NCAS has developed criteria related to both curriculum content and curriculum development and evaluation. Developmental characteristics of students from grades kindergraten through 12 are listed along with suggestions for appropriate approaches to AIDS education at each stage. Also includes staff training, what students should know, and parental and community involvement. Available in Spanish. (1988, 23 pp.; $4.00 includes p/h.)

National Coalition of Advocates for Students, 100 Boylston Street, Suite 737, Boston, MA 02116; 617/357-8507.

FINAL REPORT: PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

The Presidential Commission heard more than 500 expert witnesses and, in June 1988, delivered a comprehensive set of recommendations to the President on patient care, health care providers, research, prevention, education, societal issues, legal and ethical issues, financing, and the international aspects of the HIV epidemic.

U.S. Government Bookstore, 26 Federal Plaza, New York, NY 10278; 212/264-3826.

REPORT OF THE SURGEON GENERAL'S WORKSHOP ON CHILDREN WITH HIV INFECTION AND THEIR FAMILIES
U.S. Department of Health and Human Services

This workshop report on pediatric AIDS is written for individuals well-versed in medical terminology. Topics covered include epidemiology and transmission of HIV, supportive treatment of pediatric HIV infection, drug abuse and women's medical issues, and treatment of children with HIV infection. (1987, 102 pp.)

U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration Bureau of Health Care Delivery and Assistance, Division of Maternal and Child Health, Rockville, MD 20857; 301/443-2330.

RESPONDING TO AIDS: PSYCHOSOCIAL INITIATIVES
Carl B. Leukefeld and Manuel Fimbres

A collection of papers which were commissioned by the National Association of Social Workers, with sponsorship from the National Institute of Mental Health. The three overall objectives of this book are: to identify what is known about the psychosocial issues surrounding AIDS; to discuss the professional roles and training requirements needed to meet the psychosocial needs of individuals, families, and communities; and to identify needed services. (1987, 95 pp.; $12.95.)

National Association of Social Workers, P.O. Box 3250, Baltimore, MD 21228; 301/788-1066.

BIBLIOGRAPHIES AND DIRECTORIES

AIDS
David A. Tyckoson, ed.

Lists and summarizes the most important and readily available articles, books, and other publications for an undergraduate audience. (1986, 91 pp.; $15.)

Oryx Press, 2214 North Central at Encanto, Phoenix, AZ 85004-1483; 1-800-457-ORYX or 602/254-6156.

AIDS AND ADOLESCENTS: RESOURCES FOR EDUCATORS
Center for Population Options

A periodic bibliography on AIDS education materials. Attention is paid to dispelling myths and to the inclusion of information to prevent infection. Includes curricula, pamphlets, materials for parents, movies, and leader resources. (1987, 6 pp.; $2 + 15% p/h.)

Center for Population Options, 1012 14th Street NW, Washington, DC 20005; 202/347-5700.

AIDS INFORMATION RESOURCES DIRECTORY

A compilation of 1100 educational materials on AIDS, divided by target population. (1988, 192 pp.; $10.)

American Foundation for AIDS Research, 40 West 57th Street, New York, NY 10019; 212/333-3118.

THE AIDS INFORMATION SOURCEBOOK

This sourcebook is divided into a chronology of the AIDS epidemic; a directory of facilities including educational and counseling programs, research, and testing facilities; and a five-year bibliography of AIDS-related items, including books, articles, periodicals, films, videos, and bibliographies. (1987, 112 pp.; $35.)

Oryx Press, 2214 North Central at Encanto, Phoenix, AZ 85004-143.

A RESOURCE LIBRARY ON AIDS
Patricia Hanson, PhD

A collection of films, books, education curricula, and training guides. (1988, 10 pp.; $3, bulk rates available.)

The Rensselaerville Institute, Rensselaerville, NY 12147; 518/797-3783.

WOMEN AND AIDS: CLINICAL RESOURCE GUIDE
Women's Health Outreach

A collection of information on transmission

and risk reduction as they apply to sexual activity, drug use, and perinatal issues; a medical overview; infection control; children and teens; psychosocial issues; AIDS program development; and referrals. (1986, approximately 400 pp.; $40.)

Women's Health Outreach, San Francisco AIDS Foundation, P.O. Box 6183, San Francisco, CA 94103; 415/864-4376.

THE WORKPLACE AND AIDS: A GUIDE TO SERVICES AND INFORMATION
Allan Halcrow, ed.

A directory of organizations, education programs, consultants, and articles which focus on AIDS in the workplace. (1988, 35 pp.; 1-5 copies free, 5+ copies, $3 each.)

The Workplace and AIDS, P.O. Box 2440, Costa Mesa, CA 92628; 714/751-1883.

AUDIOVISUALS

ABOUT AIDS

This video presents interviews with experts and people of all ages, and cartoon reinforcement of the facts about AIDS. Specific AIDS-related information, including transmission, risk behaviors, condoms, and HIV antibody testing, is explained and discussed. The video provides excellent information and promotes sexual responsibility. (1987, 20 min.; $300.)

Channing L. Bete Co., Inc., 200 State Road, South Deerfield, MA 01373; 413/665-7611.

AIDS: AN ENEMY AMONG US

Sixteen-year-old Scott must come to terms with the fact that he has contracted HIV through a blood transfusion. This moving drama presents important facts as well as the anger, fear, and uncertainty that surround AIDS. Gladys Knight portrays an immunologist who helps to dispel the myths and to explain the facts to Scott's peers and family. (1988, 45 min.; $245, VHS.)

Churchill Films, 662 North Robertson Boulevard, Los Angeles, CA 90069; 213/657-5110 or 1-800-334-7830.

AIDS: CHANGING THE RULES

Ronald Reagan, Jr., Beverly Johnson and Rueben Blades host this film—directed at heterosexual adults—which clearly suggests steps individuals can take to minimize the risk of contracting HIV. (1987, 26 min.; $40, VHS or Beta; $50, ¾" videocassette)

AIDS Films, 50 West 34th Street, Suite 6B6, New York, NY 10001; 212/629-6288.

AIDS: TAKING ACTION

Intended to help young people understand the facts concerning AIDS and to encourage them to become active in the fight to control the spread of the disease. Includes a comprehensive teacher's guide. (1988; one video and one handbook, $250, plus shipping/handling, $7/package ($21 maximum charge), quantity discounts available.)

All Media Productions, Educational Division, 1424 Lake Drive SE, Suite 222, Grand Rapids, MI 49506; 616/459-9703.

AIDS: WHAT EVERYONE NEEDS TO KNOW

This newly updated teaching film explains the facts about AIDS, stresses prevention, and notes that abstinence and avoiding used IV drug needles are the only absolute ways not to be infected by the HIV virus. Interviews with people with AIDS emphasize the importance of avoiding infection. (1988, 18½ min.; $275, VHS; $390, 16mm.)

Churchill Films, 622 North Robertson Boulevard, Los Angeles, CA 90069; 213/657-5110 or 1-800-334-7830.

THE AIDS MOVIE

Features AIDS educator, David Brumbach, speaking on the importance of awareness and prevention. Paul, Sunny, and Susan, three people with AIDS, share the realities of living with AIDS. (1986, 26 min.; $450, film; $380, video; $57, rental of 16mm only.)

New Day Films, Riverview Drive, Wayne, NJ 07470-33191; 201/628-9111.

ALL OF US AND AIDS

This dramatic video models responsible sexual decision-making, from abstinence to safer sex, in a community with diverse experience and values. It follows teenagers who are making a videotape on AIDS prevention in their own style and language. Uses humor, contemporary music, and true-to-life encounters to engage young people in a dialogue on HIV prevention. (1988, 30 min.; $10 for preview and $225 for purchase.)

Peer Education Health Resource, P.O. Box 3262, Minneapolis, MN 55403.

ANSWERS ABOUT AIDS—THE SURGEON GENERAL

A question-and-answer session with Surgeon General C. Everett Koop and a classroom of teenagers. Dr. Koop dispels myths about attending school with another student with AIDS and discusses testing for HIV. Because of the limited number of specific topics covered, this video is best used as a supplement to a more comprehensive AIDS education program. (1986, 16 min.; $95.)

American Red Cross. Contact your local chapter for all resources. If there is difficulty in locating or obtaining materials, contact the Regional Operations Headquarters.

A LETTER FROM BRIAN

Designed by the American Red Cross to help teenagers understand the facts about AIDS. A letter from an ex-boyfriend forces a teenager to cope with the threat of AIDS. Workbooks and study guides are available at local Red Cross Chapters. (1987, 29 min.; available on loan free, $95, purchase.)

American Red Cross, National Headquarters, Washington, D.C. 20006; 202/639-3219 or Modern Talking Pictures, 5000 Park Street North, St. Petersburg, FLA 33709; 813/541-5763 (for loan) or 1-800-237-4599 (for purchase).

MAKING IT. . . SAFE

This video highlights the necessity of practicing safer sex. It indicates why safer sex is important and how to practice it, and encourages the incorporation of creative sensual sex techniques, with a strong emphasis on condom use. (1987, 58 min. or 30 min. for edited version; $300 or $275 for edited version.)

Cineplex Inc., 8275 Maryland, Montreal, Quebec, Canada H4P 2C8; 514/342-2340.

SEX, DRUGS, AND AIDS

This film, narrated by Rae Dawn Chong, begins with information on how HIV is and is not transmitted. Other important parts of the film include: young women talking about protecting themselves against STDs and pregnancy, five people who have AIDS telling how they got it, and a man who was previously homophobic talking about how his attitudes changed when he watched his gay brother die of AIDS. (1986, 17 min.; $400, 16mm; $325, video; $75, rental.)

Select Media, 74 Varick Street, New York, NY 10013; 212/431-8923.

THE SUBJECT IS AIDS

This video, based on *Sex, Drugs and AIDS* (see above), includes some changes which make it appropriate for a younger (junior high) audience. It emphasizes abstinence as the key form of AIDS prevention. It includes an introduction by Surgeon General C. Everett Koop on the importance of AIDS education. The scene, in which a man talks about his gay brother who has died of AIDS, has been replaced by three teens who give their views on AIDS. (1987, 18 min.; $400, 16mm; $325, video; $85, rental.)

Select Media, 74 Varick Street, New York, NY 10013; 212/431-8923.

TOO LITTLE, TOO LATE

In this documentary, members of families of people with AIDS share their pain and frustration, and the solace they have derived, while helping their loved ones die peacefully. The film features Barbara Peabody, artist and author of the book, *THE SCREAMING ROOM.* The film provides a sense of the experiences of families of people with AIDS. (1987, 48 min.; $75, rental; $400, purchase.)

Fanlight Productions, 47 Halifax Street, Boston, MA 02130; 617/524-0980.

YOUNG PEOPLE AND AIDS

This video has the same format and information as *ABOUT AIDS,* except the interviews are with school age individuals and the section on HIV antibody testing is not included. Best suited for middle/junior high school students. (1987, 18 min.; $300.)

Channing L. Bete Co., Inc., 200 State Road, South Deerfield, MA 01373; 413/664-7611.

AIDS ORGANIZATIONS

The following organizations provide information, research and/or services on AIDS. Some publish pamphlets, booklets, and newsletters. Contact them directly for more information.

AIDS Action Council, 729 8th Street SE, Suite 200, Washington, DC 20003; 202/547-3101.

The AIDS Institute, New York State Health Department, Empire State Plaza, Corning Tower, Room 1931, Albany, NY 12237, 1-800-462-1884.

AIDS Information Exchange, U.S. Conference of Mayors, 1620 Eye Street NW, Washington, DC 20006; 202/293-7330.

AIDS Information, U.S. Public Health Services, Office of Public Affairs, Room 721-H, 200 Independence Avenue SW, Washington, DC 20201; 202/245-6867.

AIDS Public Education Program, American Red Cross, 1730 D Street NW, Washington, DC 20003; 404/329-2891.

AIDS-Related Discrimination Unit, American Civil Liberties Union, 123 West 43rd Street, New York, NY 10036; 212/944-9800.

American Foundation for AIDS Research (AmFAR), 40 West 57th Street, Suite 406, New York, NY 10019; 212/333-3118.

American Red Cross, 1730 E Street NW, Washington, DC 20006; 202/639-3223.

Center For Population Options, 1012 14th Street NW, Suite 1200, Washington, DC 20005; 202/347-5700.

ETR Associates, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA 95061; 408/438-4080.

Gay Men's Health Crisis, Box 274, 132 West 24th Street, New York, NY 10011; 212/807-6655.

Institute for the Protection of Lesbian and Gay Youth, 110 E. 23rd Street, 10th Floor, New York, NY 10010; 212/473-1113.

Lambda Legal Defense and Education Fund, 132 West 43rd Street, New York, NY 10036; 212/944-9488.

Mothers of AIDS Patients (MAP), c/o Barbara Peabody, 3403 E Street, San Diego, CA 92102; 619/234-3432.

National AIDS Network, 2033 M Street, Suite 800, Washington, DC 20036; 202/293-2437.

National Association of People with AIDS, P.O. Box 65472, Washington, DC 20335; 202/483-7979.

National Coalition of Gay STD Services, P.O. Box 239, Milwaukee, WI 53201; 414/277-7671.

National Hemophilia Foundation, 110 Green Street, room 406, New York, NY 10012; 212/219-8180.

National Leadership Coalition on AIDS, 1150 17th Street NW, Suite 202, Washington, DC 20005; 202/ 638-0001.

National Lesbian and Gay Health Foundation, P.O. Box 65472, Washington, DC 20035; 202/797-3708.

Planned Parenthood Federation of America, 810 Seventh Avenue, New York, NY 10019; 212/541-7800.

San Francisco AIDS Foundation, P.O. Box 6182, San Francisco, CA 94103; 415/864-4376; 415/ 864-4376.

Sex Information and Education Council of the U.S. (SIECUS), 32 Washington Place, New York, NY 10003; 212/673-3850.

NATIONAL AIDS HOTLINES

National AIDS Hotline: 1-800-342-AIDS

National Institute on Drug Abuse: 1-800-662-HELP

National Gay Task Force: 1-800-221-7044

AIDS Crisisline: 1-800-221-7044

STD National Hotline: 1-800-227-8922

AZT and Related Drugs: 1-800-843-9388

Index to Volume XVI

September 1987–July 1988

Articles—Titles

Articles—Authors

Audiovisual Materials Reviewed

Book Reviews and Titles