

THE INVISIBLE BRIDGE Child Sexual Abuse and the Risk of HIV Infection in Adulthood

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Despite HIV prevention education efforts, some people report an inability to alter their sexual behavior to reduce the risk of HIV transmission.¹ Researchers have not adequately explained this phenomenon but have identified problems in HIV prevention education, ranging from difficulties reaching target audiences to socioeconomic, racial and cultural constraints. Most investigators have missed a more subtle, but tenacious, connection that may explain this inability, namely the relationship between childhood sexual abuse and HIV infection. While childhood sexual abuse has been previously associated with bulimia nervosa;² drug addiction;³ and with drugs and alcohol as factors confounding safer sexual behavior;⁴ the connection between childhood sexual abuse and HIV infection has not been extensively explored.

Underreporting of Cases

At present, it is estimated that nearly 500,000 children each year are sexually abused.⁵ However, it is notable that previous reports indicate that perhaps less than 6% of child molestations are ever reported.⁶ Some studies suggest that between 20% and 60% of women have experienced incestuous and/or extrafamilial sexual abuse. The figures reported for men are further complicated by stigma and gender-role identifications. However, some studies indicate that as many as 16% of men have experienced incestuous or extrafamilial sexual abuse.⁷ Additionally, a study conducted by the Canadian Government found that one third of male subjects had experienced some form of sexual abuse.⁸ Underreporting, an alarming element of child sexual abuse, is mirrored in the HIV/AIDS epidemic.

In fact, although nearly 250,000 cases of AIDS have been reported in the United States by the Centers for Disease Control (CDC), a significant number of people are not reported for a variety of complicated reasons. Because of the common transmission routes (i.e., drug use and anal and vaginal intercourse), there has been additional stigma attached to the disease which presents ob-

stacles to reporting analogous to those of childhood sexual abuse. While epidemiologists make efforts to reconstruct and examine future trends in the AIDS epidemic, a realistic picture of the number of people affected is difficult.⁹ An extremely conservative 1990 estimation of the cumulative number of HIV-infected individuals in the United States was 1,050,000 with a plausible range of 850,000 to 1,205,000.¹⁰

As these twin epidemics gain greater recognition, and more information is made available, the connection between HIV/AIDS and childhood sexual abuse will become clearer. One recent study examined the prevalence of childhood sexual and physical abuse in HIV-infected adults. Interviews resulting from this study indicated that a disturbing 65% of those infected reported physical or sexual abuse in childhood.¹¹ The authors of the study additionally pointed out a connection between abuse-survivor characteristics and behaviors which increase the risk for HIV infection.

The Counselor's Role in Public Health

This article will examine the association of the symptoms of childhood sexual abuse and transmission modes for HIV. Although HIV — as has been noted of sexually transmitted diseases¹² — may be transmitted by the perpetrator during sexual abuse and is a serious matter which merits attention, this article will be limited to strategies for identifying and sensitively working with adult abuse survivors. Counselors can and must add to the general public health by helping to reduce the risk of HIV transmission in individual clients. School psychologists, guidance counselors, health educators, social workers, nurses, and psychotherapists, are offered a unique opportunity to reduce HIV transmission through work with the individual. "Helping professionals" can identify the obstacles to HIV prevention and help the individual client to interpret safer sex guidelines not as an abstract imperative, but as an integrated health behavior. The childhood sexual abuse survivor is at greater risk for HIV infection.

Understanding how the after-effects of childhood sexual abuse present barriers to precautions against HIV will inform more effective treatment measures and prevention interventions.

Defense Mechanisms and HIV Risk Behavior

A number of symptoms and after-effects of childhood sexual abuse present a particular danger for some adult survivors in increasing their risk of becoming HIV-infected. In attempting to make sense of the inability of adult sexual abuse survivors to practice safer sexual behavior consistently, it is important to understand certain psychological defense mechanisms that are common among many survivors. These mechanisms include denial, dissociation, repetition compulsion, and splitting. A brief description of each mechanism will be helpful.

Denial may cause an adult survivor to assert that sexual abuse has little or no impact on his or her life and behavior. It can also lead the survivor to believe that the original abuse has been dealt with, when in actuality, the individual is still showing many symptoms of its negative effects. Denial can therefore allow the survivor to deny risk behaviors or to label and comprehend them as something else. In terms of HIV transmission, the defense of denial creates a subtle yet potent obstacle to the implementation of HIV prevention education messages. In fact, denial allows the individual to "tuck away" uncomfortable thoughts, often creating a kind of skewed perception. For example, a young adult who may very well understand the risk of unprotected sexual behavior, may use denial to allow a continuation of the behavior. ("We were just playing around," or "I pulled out before anything happened," or "My partner is too healthy to have anything I could catch.") It is important to note that denial — like the other defense mechanisms — is an unconscious response which operates largely outside of a person's control as long as it remains unexamined. A person employing denial is often unable to comprehend a different interpretation of his or her behavior. Therefore, suggesting that not using a condom and not assessing HIV risk may indicate self-destructive behavior may not be "heard" by the survivor. It is imperative that the survivor first come to "see" — without denial — the behavior, before he or she can observe it, label it, and understand it. In this sense, the therapeutic helper is also a witness and may be most effective by mirroring the survivor's behavior to reduce denial.

Dissociation — perhaps the most common survivor defense — is the mechanism which initially allowed survival of the sexual abuse trauma. Dissociation originally worked by helping the survivor to remove him or herself from the reality of the incident while it was occurring. However, dissociation may continue to be used by the adult survivor. Counselors can usually identify this defense during a session; the survivor's eyes glaze over. Survivors may also talk about "zoning out," "spacing out" and "going blank." Survivors often dissociate during times of increased emotional intensity, especially during sexual behaviors. As an adult, then, the survivor has developed a way of coping by pushing the existence of painful experiences and intense feelings into the unconscious. Survivors often report that they "go numb" during

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sexual activity, falling back into a once-useful pattern of dissociating from their bodies in order to tolerate abuse experiences. In this way, the survivor may not "be present" for sexual behavior that may put him or her at risk for HIV infection. This mechanism, then, may interfere with the survivor's ability to employ appropriate protection to avoid HIV infection.

Repetition compulsion is a defense mechanism which causes the survivor to compulsively and repeatedly put himself or herself in the presence of an anxiety-producing situation in order to have a sense of mastering fear. The survivor's compulsive repetition sometimes may feel out of the realm of the person's control. Such a mechanism, therefore, may play a role in putting the survivor at greater risk for HIV infection. The compulsive aspect of this mechanism makes it difficult to incorporate safer sexual behavior until the survivor learns to observe and anticipate the compulsion itself.

Splitting may be the most easily recognized defense mechanism and comes from a survivor's inability to tolerate ambivalence. The survivor is often unable to experience simultaneous contradictory feelings and may therefore experience himself or herself and others in extreme or unidimensional ways. For example, a survivor may experience other people as all good or all bad. Splitting also allows the survivor to detach certain aspects of his or her persona or behavior and repress these aspects into the unconscious. This mechanism often manifests as a persistent black-or-white-only perception of the world. In this way, the survivor may not be able to comprehend fully that sexual activities can be both pleasurable and also potentially harmful unless precautions are taken. Additionally, although the subject may act sexually and directly risk HIV infection, he or she may not believe that the kind of sexual activity in which he or she participates puts him or her at risk due to splitting. For example, a patient of mine had been molested for several years by a "friend of the family," and although the abuse was steady, it did not include intercourse. The client now unconsciously understands intercourse to be "good" and other sexual behaviors (including foreplay, touching, kissing) to be "bad." Splitting allowed the survivor to "split off" those other kinds of sexual activity while still getting pleasure from unprotected intercourse. Despite preventive education messages that the risk of infection is a "bad" thing, the survivor unconsciously understands the behavior associated with the abuse as bad, and, in the case of the example, the intercourse remains unspoiled. In the survivor's voice, splitting is experienced as follows: If things are either "all good" or "all bad" how can sexual behaviors be "good" yet involve something "bad?"

Symptoms of Child Sexual Abuse and HIV Risk

Childhood sexual abuse can manifest as a number of symptoms in the adult survivor that may impact sexual behaviors and risks for HIV infection. For the sake of explanation, the symptoms have been grouped into three clusters. The first cluster of symptoms involves sexual behavior and difficulties. These symptoms include a negative self-concept, body alienation, and sexual and sex-role distortions. Typical symptoms of incest and childhood sexual trauma can include a period of promiscuity¹³ or

RECOGNIZING THE WARNING SIGNS

A first step to helping survivors make the connection between child sexual abuse and adult HIV safer sexual behavior is recognizing the warning signs of abuse.

The following are signposts which may indicate a history of abuse:

- Family environment in which there is little nurturing or protecting of any kind.
- Household in which physical and emotional abuse also occur.
- Family, though very disorganized, usually presents a closed front to the world. For example, the parents may forbid friends and outsiders to visit, or the parents may embarrass the child in front of friends to such a degree that the child no longer gets visitors in the home.
- Adult who has not learned to protect him or herself and experiences repeated re-victimization.

prostitution.¹⁴ (Studies indicate that 75% of prostitutes report sexual abuse histories.¹⁵) Included in this cluster is "sexual compulsivity." In general, survivors can be classified into two predominant styles of sexuality as follows:

Survivors tend to become socially and sexually withdrawn or indiscriminately sexually active. . . . [The latter] may allow the survivor to own herself, to continue to feel special power over men [or women] and to use them sexually, or to get back at the abuser. [This also puts the survivor at greater risk for] revictimization, unwanted pregnancies and abortions and sexually transmitted diseases.¹⁶

Missing from this list is HIV infection. In so far as the survivor is at risk for unwanted pregnancy, revictimization (including rape), and sexually transmitted diseases, he or she is also at risk for HIV infection. Similarly the survivor who is sexually indiscriminate may directly increase his or her risk for HIV infection.¹⁷

The second cluster of symptoms is organized around drug and alcohol dependency. The connection between chemical dependency in adulthood and previous childhood sexual abuse has been noted frequently. The impairment in judgment from alcohol and drug use threatens to reduce the survivor's ability to take precautions against HIV infection. Stall and colleagues found that people who drank even rarely during sexual activity were about two times as likely to be at high risk for HIV infection compared to those who abstained from alcohol during sex.¹⁸ This study also found an increase in risky sexual practices depending on the drugs involved. The increase in risk was greater if the drugs consumed were

illegal rather than legal or easily available. For injection drug users there may be a double risk of sharing unclean needles and having unprotected sexual intercourse.

The final cluster of symptoms of childhood sexual abuse affect self-perceptions and interpersonal relations. Many times rather than accept that a trusted adult violated boundaries and acted violently, the child will blame herself or himself for the sexual abuse. This phenomenon is incorporated into a perception that the child is responsible for the abuse. Further, because of the betrayal of a trusted adult, the survivor may have trouble trusting others and maintaining clear and appropriate personal boundaries. Failure to set and reinforce appropriate limits — such as using condoms during sexual activity — is considered to be a leading cause of HIV transmission for survivors. Indeed, for a survivor who feels worthless or inherently bad, there is no impetus toward safer sexual behaviors. This phenomenon is intensified in the survivor who perceives his or her personal value to be derived from sexual interactions. Trying to negotiate precautions during sexual activity may be perceived by the survivor as risking rejection. Often the survivor complies with dangerous sexual practices to maintain equilibrium. Further, survivors have difficulty saying no, and their ability to negotiate safer sexual practice is therefore impeded.

Depression may be one of the most common symptoms of childhood sexual abuse and belongs in this final cluster. Feeling hopeless, powerless and worthless will clearly reduce the survivor's ability to advocate for himself or herself with proactive precautions against HIV infection. Furthermore, unlike depressed people who have not had

to survive sexual abuse, depressed survivors are more likely to engage in self-destructive and actively (or passively) suicidal behavior.¹⁹ These behaviors often include excessive sexual risk taking and drug use. Additionally, isolation, loneliness, and withdrawal appear in this cluster, and are connected with a tendency to keep secrets. The sexual abuse survivor has often carried the deep secret for a long time and is generally fearful that he or she will ultimately be exposed as being "bad." In terms of risk for HIV infection, this isolation and secrecy may cause survivors to engage in high risk behavior yet prevent them from seeking help regarding the risky behavior.

Implications for the Therapeutic Professional

Survivors often minimize or downplay the effects of the abuse or have no conscious recall of the event(s). In this way, the survivor may be suffering from symptoms or experiencing pain for which he or she has no explanation. Rarely is this kind of memory repression limited to a single event, and it may ultimately prevent the survivor from understanding his or her own behavior and from perceiving the consequences of it. Enhancing this difficult problem is the issue of secrecy. The counselor must be able to encourage the client to share feelings about the trauma and to help the client make sense of what has happened. The counselor must not seem voyeuristic, yet must show a clear and direct wish to hear and understand. The counselor may need to ask questions to help the survivor clarify what happened. In this way, the survivor begins to share pain and to release some of the binds that hold the secrets of the abuse.

Often times after a disclosure, the survivor may feel a conflict between the need to go back and deny the abuse and the need to continue with the work. The counselor needs to be able to support the continued work while understanding the wish of the subject to reconceal the trauma. Denial and difficulty working with the sexual abuse are not limited to the survivor. In fact, the counselor needs to work through the feelings stirred up by hearing about the abuse. This work should be done "outside the therapeutic relationship by seeking supervision and the support of peers."²⁰ Counselors must be able to tolerate what they hear and seek adequate assistance when needed.

The counselor by virtue of having been told of the abuse by the survivor helps him or her to continue therapy by verifying and validating the experience. The client should not be allowed to divert attention from the abuse nor minimize its importance. A general goal of treatment is to alleviate the negative effects of the abuse and help the survivor make sense of and incorporate the knowledge into a new understanding. By helping the survivor be more aware of the symptoms or secondary elaborations of abuse, the counselor helps the survivor gain greater mastery over his or her life, health, and sexuality. This helps the survivor to move cognitively from victim perception toward support and self-empowerment. This awareness will also help the survivor to be more aware of risk behavior and may help reduce the risk of HIV infection. Although symptoms do not simply disappear by being discussed, symptoms may nonetheless be accounted for and anticipated so that the survivor may utilize concrete prevention and coping tools.

National Speakers Bureau The National Association of People with AIDS (NAPWA)

David, 20, stood before a group of about 40 teenage students at Beth Al Temple in Alexandria, Virginia. David looked out over the group and asked a question. "How many of you know someone who has AIDS?" Suddenly the room was very quiet. Two people timidly raised their hands. "Those of you who don't have your hands raised can put them up now. My name is David and I have AIDS."

The National Speakers Bureau of the NAPWA provides schools, corporations, community groups, and professional organizations with the most effective weapon in the fight against AIDS: the voice of experience.

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GAY AND LESBIAN CHILDREN

Perceiving and anticipating a child sexual abuse history in clients becomes particularly important when considering the childhood of gay and lesbian people. In the spectrum commonly understood as sexual abuse — from sexual innuendo and leering to ritualistic or Satanic sexual abuse — there is verbal abuse. This can include denigration of the child's genitals, sexual ability, or sexual orientation.

Clearly, gay men and lesbians in this society are common subjects for denigration and verbal attacks, making the implication for the prevalence of sexual abuse enormous.

In light of the fact that victims of childhood sexual abuse are prone to revictimization, the implications for gay men and lesbians are striking. In other words, because gay and lesbian children are routinely and consistently traumatized for being different, they may be more likely to experience additional trauma. Richard Isay makes a related point in *Being Homosexual* (New York: Avon, 1990). He describes that the (male) homosexual child begins to perceive a difference about himself in relation to others. This point is important for two reasons. The first is that a child's feeling of being different is often not perceived in the

sense of being "special" but rather in the sense of being "different from" — alien. This feeling of being different often evokes a self-protective secrecy that can be easily manipulated by a perpetrator. Gay or lesbian children understand that they must keep their "difference" a secret.

The second point that Isay's observation brings out is that the father may perceive this difference on the part of the child and pull away from the child as a result. This withdrawal may increase the child's feeling of being flawed, and further reduces the parent's protection of the child or the child's protection of himself or herself. Isay notes that the father may not be aware of the reasons he pulls away from the homosexual child, but often does so in favor of another sibling. The child is left with the difficult task of interpreting this rejection and may be more vulnerable to inappropriate attention from another adult who may use this situation for sexually abusive purposes. Thus the child may be further distinguished as easy prey to the perpetrator. The wounds of the gay or lesbian child demarcate those of a potential victim, possibly preparing the adult for greater availability for re-victimization.

Tips for Counselors

- While a survivor may exhibit symptoms that clearly suggest a history of sexual abuse, it can be extremely traumatic for a person to be "told" by a counselor about the abuse. For the survivor unaware of the abuse, forced awareness can lead to a disturbing doubt of reality and a trauma which may cause a termination in the therapeutic relationship.
- The counselor might suggest that the symptoms expressed have been related to others who have been sexually abused. This approach may prompt a memory or an association and lay the groundwork for further exploration. In any event, the counselor can continue to work with the symptoms without necessarily attributing meaning to them in order to help the survivor gain greater insight into difficulties.
- Continual assessment of a survivor's level of functioning is important in a therapeutic relationship. The counselor can help the survivor to identify strengths and sources of support and encourage such components. As new discoveries are made and obstacles overcome, reassessments must be made.
- The counselor can best function by mirroring the survivor's feelings, perceptions, and behaviors and pointing out patterns. Becoming aware of behaviors is an important first step toward a durable change. As the survivor becomes more insightful about actions and feelings, prevention techniques may be more accepted.
- The counselor may need to intervene where necessary. It is vital that the counselor understand that risking HIV infection is self-destructive behavior.
- The father or household head in an incestuous family is usually an excessively controlling, dominating force within the family and often uses physical force to assert his power. Outside of the family, the father may present himself as a quiet, solid family man who is a good citizen and provider.
- A person who has been sexually abused may also have a battered mother or an alcoholic parent(s).
- A child who has been sexually abused may have been parentified (forced to act as the parent or caretaker in the family).
- Refusal to contact family members or avoidance of the family, in general, may indicate past sexual abuse.
- Fear of a particular family member may be expressed by childhood sexual abuse survivors and merits further exploration.
- Clients who talk about incest reported by another family member may also have experienced sexual abuse as children.
- Parents in families where sexual abuse occurred are often expert at manipulating the context of a situation and shifting reality.

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Conclusion

Careful exploration between client and counselor of the interconnectedness of childhood sexual abuse and HIV risk behaviors can lead to greater self-awareness and sexual health. Sensitive exploration of the long-range effects of child sexual abuse can foster greater self-empowerment and facilitate self-healing. This

work can and must be seen as an imperative contribution on an individual level to reducing the spread of HIV.

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The New York City Gay and Lesbian Anti-Violence Project

Should rapists be tested for HIV at the demand of their victim? Should only convicted rapists be tested? Is the survivor's need to know more compelling than an accused rapist's right to privacy? Is forced testing yet another manifestation of AIDS hysteria, grounded in racism, sexism, classism and homophobia?

The controversy over mandatory testing of accused and convicted rapists has sprouted up throughout the country, with proponents winning most battles. Many rape survivors are terrified of having been infected with HIV through assault; they are desperate for answers and reassurance. Sexual assault survivors and their advocates are constantly frustrated by systems that allow rapists to go unpunished and treat survivors poorly. On the other hand, HIV-positive people and their advocates often encounter ignorance, fear, and hysteria of HIV/AIDS. This kind of stigma has created an atmosphere of bigotry and hatred of groups seen as "spreading" AIDS, such as drug users, gay men, lesbians, women, prostitutes, and homeless people.

A person can contract HIV as a result of sexual assault, but the level of risk is unknown. The onset of the AIDS crisis added a new fear for victims and survivors of sexual assault, compounding the psychological and physical traumas associated with rape. Survivors' fears about contracting HIV have been documented without concomitant analyses of the actual potential for HIV transmission through sexual assault. However, because HIV can be transmitted through blood, semen, and vaginal secretions, some acts associated with increased risk of HIV transmission (from an assailant who is infected) include: penile penetration, ejaculation, brutality causing internal or external cuts or abrasions, multiple sexual assaults by one rapist, multiple assailants, high concentration of HIV in the assailant's blood, and presence of genital ulcers in the survivor.

Over half the states in the country test charged or convicted rapists for HIV, with the laws varying from state to state. Some laws permit testing only after the defendant has been convicted; others permit testing before conviction. While a court order authorizing testing is required by all states that regulate HIV-antibody testing, different standards apply. For example, in some states, the procedure for getting an order to force the defendant to submit to the HIV antibody test is the same as getting a search warrant. Other states require a more rigorous procedure.

Many laws authorizing testing were enacted along with "disclosure" statutes which impose criminal penalties on HIV-infected persons who do not inform their sexual partners of their HIV status. For example, in April 1992, a 30-year-old South Carolina man was sentenced under a 1988 law to four years in prison for failing to tell two men with whom he had consensual sex that he was HIV-positive. Neither of the men tested HIV-positive following the encounter.

While policy makers and public health officials agree that voluntary anonymous HIV testing is critical to efforts to reduce HIV transmission, mandatory testing for certain kinds of people (including drug users, homeless people, people accused or convicted of committing crimes, prostitutes, couples seeking marriage licenses, and gay men) has been widely debated. Where rape is concerned, there are compelling arguments on both sides. Unfortunately, the issue is often wrongly simplified into two camps, where those opposed to mandatory testing are considered "pro-rapist," and those in favor of testing are "pro-survivor." Unfortunately, this polarization blurs the complexity of HIV transmission, disregards the real needs of rape survivors, and undermines the right to privacy.

Proponents of mandatory testing for accused or convicted rapists argue that the rape survivor has a right to know if HIV was transmitted during the assault, which prevails over the rapist's right to privacy. However, opponents of mandatory testing point out that testing an accused or convicted rapist does not offer the survivor any definitive information about his or her HIV status. This is because, so far, the most reliable and widely used HIV test indicates the presence of antibodies to the virus that may not be detectable for six months or longer after infection occurs. Even as new more accurate tests are perfected and marketed, a positive test result in a rapist will not indicate if transmission has occurred.

The terms that underlie the current debate over mandatory testing of rapists focus the argument on rape by strangers, ignoring the fact that most rapes are perpetrated by relatives and acquaintances of the victim. Additionally, the survivor's recovery is often left out of these debates. In fact, forced testing may inhibit and delay recovery of the survivor whose focus will be on the test results and the perpetrator instead of personal issues of recovery. Finally, these debates tend to overshadow the offense of rape, since HIV has assumed greater attention and priority than the crime of rape.

NON-CONSENSUAL SEXUAL EXPERIENCE & HIV EDUCATION An Educator's View

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"Feelings are 100% okay," I tell a group of thirty high school students.

They stare back blankly.

"Whatever you feel about whatever we talk about today is 100% okay." They shift in their seats, eyebrows raised.

I know what they are thinking:

Feelings? I thought this was a class about AIDS?

The connection is easy to make.

"Today we're going to talk about AIDS and HIV disease, which means we're going to talk about things that can bring up a lot of different feelings."

The list is familiar: people who have sex with a same-gender partner, drug and alcohol use, fear of infection, knowing someone who is HIV-positive, being HIV-positive, and past or present sexual experiences.

I watch the faces and movements of the students. They are listening intently, particularly to the part about sexual experiences.

"Some of us haven't had any sexual experiences. Some of us have had sexual experiences that felt good and were consensual. And some of us have had sexual experiences that were uncomfortable, or that we didn't choose, or that we were forced to have. I need to talk with you about HIV prevention, and that means I need to talk explicitly about forms of sexual intercourse that present a risk of transmission when preventive measures aren't used. I know that for some of us, the information may be difficult or uncomfortable to hear because of our past or current sexual experiences. It's okay."

I look around the room. Arms and bodies are relaxing. Everyone is listening and making eye contact, including the few male and female students who, at the start of the class, were studiously observing the floor tiling.

Consensual Sex Assumption in HIV/AIDS Prevention

I began using the above approach in HIV/AIDS prevention workshops when I realized that the information I taught — information about anal intercourse, vaginal intercourse, and oral intercourse — mirrored for some individuals their abusive or non-consensual sexual experi-

ences. In this article, sexual abuse is defined as a violation perpetrated by someone with power over someone who is vulnerable.¹ This violation takes a sexual form and may include physical, verbal, and emotional components. This definition is inclusive of the common names we give to sexual violation, including rape, date-rape, domestic violence, sexual assault, sexual harassment, incest, and sexual molestation. Every day, every minute, in the United States, individuals of both genders, of all sexual orientations, identities, races, and of all ages, are being forced to have sexual intercourse. Others are exchanging sexual activities in ways that are generally considered "consensual," but that may, in fact, feel non-consensual. These activities may include, for example, exchanging sex for money, exchanging sex for a place to sleep, exchanging sex to keep a job, or agreeing to have sex out of a sense of obligation. For the purposes of this article, non-consensual sexual activity is defined as any form of sexual activity that may be or feel unwanted. Additionally, the word "victim" herein refers to a person who is presently being sexually abused or experiencing non-consensual sex. "Survivor" refers to a person who is no longer being abused or experiencing non-consensual sex.

In a May, 1992 testimony to the National Commission on AIDS, SIECUS' Executive Director, Debra Haffner wrote:

It is also important for us to remember that not all adolescent sexual behaviors are voluntary. One in four girls and one in six boys report that they have been sexually assaulted. Recent studies report much higher rates of sexual intercourse among teens who have been abused, including higher rates of pregnancy and multiple partners (Select Committee on Children, Youth, and Families, 1992).²

It is extremely important for us to incorporate this knowledge into current HIV education efforts.

Much of HIV education, in fact, is derived from a "consensual sex assumption." As an underlying philosophy, it

assumes that the majority of sexual activity is consensual and drives such prevention slogans as, "Talk to your partner," and "Using a condom is as easy as putting on a sock." Safer sex education programs derived from a consensual sex assumption often have a "cheerleading" element, focusing on the pleasurable aspects of safer sexual behaviors. While positive aspects of sexuality are important to emphasize, the consensual sex assumption has shaped our current prevention efforts much to the exclusion of people who do not feel empowered in relationships, whose consensual sexual relationships are not pleasurable, and whose non-consensual relationships do not allow room for negotiation. The concept of negotiation itself is, in fact, based in a consensual sex assumption that individuals believe in their own power and rights and have a relationship in which those rights are respected.

HIV Education and the Survivor or Victim

According to the statistical reality of sexual abuse and non-consensual sex, every audience or group has individuals who have been sexually abused or have had relationships or encounters that involve non-consensual sex. For survivors and victims, HIV education — as well as sexuality education in general — can be an uncomfortable and threatening experience. It is my belief that the responses of individuals to HIV and sexuality education can sometimes be misinterpreted as erotophobic, sometimes even homophobic. Survivors and victims may not necessarily fear the erotic or fear homosexuality. They may, however, fear abuse and sometimes express it in educational forums. *[See box on this page.]* Survivors and victims bring to prevention education workshops the experience of abusive or non-consensual sexual activity with opposite or with same-gender perpetrators.

For survivors and victims, the language and content in HIV education can trigger past or current experiences, and can lead to dissociating or even physical illness. For an individual who has been forced to engage in oral intercourse, a discussion about safer oral sex can be unsettling. In HIV and sexuality education trainings, survivors and victims may experience anything from vague feelings of discomfort, guilt, or shame to actual memories of abuse. It can be difficult to hear or absorb important HIV prevention information. Penis models or sexually explicit brochures, for instance, can be particularly troublesome for survivors and victims. A survivor in a safer sex workshop, conducted by another HIV educator, confided in me, "There were penises everywhere. I couldn't think."

Understanding Behaviors

In addition to affirming feelings, HIV education needs to incorporate an acceptance of the behaviors of survivors and victims that is based on an understanding of the effects of sexual violation. Many of the effects of sexual abuse and non-consensual sex translate into behaviors that directly impact the survivor's or victim's ability to prevent HIV exposure. It is important to note that not all survivors or victims experience the same effects and behaviors. In fact, some behaviors can be supportive of HIV prevention. For example, survivors and victims may be sexually abstinent and may avoid alcohol and drug use. Others may strive for "perfection," using safer sex to avoid "making a mistake."

Case in Point

Homophobic responses to HIV and sexuality education can sometimes be an indication of past or current abuse by a same-gender perpetrator, whether or not the abuse is remembered or identified. A male student in a class I worked with became extremely upset when he learned that an HIV-positive gay male speaker would be coming to talk. His language was clear, hostile, and unacceptable. "If that faggot comes near me, I'll beat him up." The teacher's first approach was to address what she considered to be the underlying cause of the student's response — fear of homosexuality. As the other students listened, she assured him, "Just because a man is gay, does not mean he will be attracted to you." The student was not convinced and continued to be extremely fearful and vocal about it. The teacher then responded to the student's fear of being touched. She let the student know that inappropriate touch was not okay, and that in her classroom he would be physically and emotionally safe. They had a mutual discussion about personal space and boundaries. The student became calmer and seemed satisfied.

What then followed was an open discussion, not about homosexuality, but about abuse. The student who was afraid of being touched inappropriately, as well as the other students, initiated a conversation about past sexual abuse. The teacher gently discussed the difference between abuse by a same-gender perpetrator and homosexuality.

Sexual abuse has to do with power and inappropriate sexual attention on the part of the perpetrator. It has to do with violation and assault. Sexual abuse perpetrators can be male or female, homosexual or heterosexual. Most sexual abuse perpetrators, however, identify as heterosexual, regardless of the gender of their victims. The choice of a victim by a perpetrator is often determined by the availability of the victim, not by gender. In contrast, SIECUS defines sexual orientation as one's erotic, romantic, and affectional attraction to persons of the same gender, the opposite gender, or both. Sexual abuse perpetrators, victims, and survivors can identify as either heterosexual, homosexual, or bisexual, which are believed to be formed independent of the abuse.

It is important to note that fear of abuse and fear of homosexuality are not the same thing, although the manifestations of fear can be similar. Survivors and victims of same-gender perpetrators (as well as others) may have difficulty sorting through the distinctions in a culture that offers no positive, healthy images of homosexuality and that does not promote precise definitions and clear explanations about sexual abuse or sexual orientation.

TIPS FOR INCORPORATING SEXUAL ABUSE AND NON-CONSENSUAL SEX INTO HIV EDUCATION AND PREVENTION PROGRAMS

- Assume that every group has participants who are survivors or victims of sexual abuse and non-consensual sex. Understand and accept that some participants may currently be engaging in behaviors that put them at risk for HIV infection due to past or current abuses.
- Establish ground rules or boundaries of safety. Acknowledge that the content of the program can bring up feelings for participants. Let participants know that there are no good or bad feelings. All feelings are 100% okay. Let participants know that feelings "just are," and it is the behaviors that are negotiable. Affirm for participants that feelings can come up before, during, and after the workshop. Urge participants to take care of themselves and make a list of referrals available.
- Have a policy of no surprises. At the beginning of the program let participants know the sexual terminology you use in the workshop (i.e., penis, rectum, anal intercourse, vaginal intercourse, oral intercourse, etc.) Also disclose the specific content of the program (i.e., condom demonstration using fingers, penis model, etc.) Understand that realistic models, as well as explicit discussion of sexual activity, can trigger intense discomfort, feelings, memories, or dissociation for survivors and victims. Reaffirm and acknowledge feelings throughout the discussion of sexual transmission and prevention.
- Avoid focusing on terms such as sexual abuse, incest, rape, date rape, etc. For many people these labels are threatening. Often survivors and victims do not identify what has happened, or what is currently happening, as abuse. Use less-threatening terminology, such as "forced sex," "sex we didn't choose," "sex because you feel obligated." This language allows participants to identify with their own behaviors and experiences without judgment or threat.
- Avoid language that labels sexual behavior. Do not use words like "promiscuous," "slut," "prostitute," "easy," "stud," "hustler," etc. These labels only trigger shame, especially for survivors who have been verbally abused.
- Focus on feelings and behaviors. Avoid replicating what sometimes occurs in substance abuse/alcohol awareness programs in which the focus sometimes remains with the substance rather than the underlying behaviors. Give the issues a context, (i.e., "Some of us have been out on a date and been forced to have sex that can put us at risk for HIV infection. What might I do to keep myself safe in that situation?")
- Avoid easy prevention slogans (prevention by bumper sticker) and statements that convey blame, shame, or guilt.
- Be patient in explaining the differences between sexual abuse and sexual orientation. Homophobia is everywhere, and many people confuse same-gender perpetrators with homosexuality.
- Understand that some survivors and victims have been or are currently forced to engage in sexual activity with animals. Respond seriously and gently to all questions regarding the transmission of HIV between animals and humans.
- Examine the process of each workshop. Incorporate without judgment the behaviors of survivors and victims that assist and inhibit HIV prevention into teaching exercises and role plays.

Behaviors inhibiting HIV prevention are many. Survivors and victims may experience a lack of boundaries around their bodies, and believe that what a partner wants is more important than what they want. Many feel shame or guilt about sexual activities, especially when sexual activities are pleasurable. Survivors and victims may be or may have been involved in relationships which are abusive or in which an imbalance of power is notable. Survivors and victims may struggle with addictive or troublesome use of alcohol, drugs, food, and sex. Some believe that their worth is primarily sexual, which can result in exchanging sex for money, housing, or food. Survivors and victims may be unable to stay present during sexual activities, and may have the experience of not being in their bodies during sexual relations. Survivors and victims may be unwilling

to touch their own bodies or a partner's body. Many disregard their own health and minimize the danger and risks to their bodies. In general, survivors and victims find it difficult to ask for help, to state their own needs, or to accept help and support.

Rather than ask why an individual has multiple partners, or injects drugs, or cannot say "no" to a partner, or does not take care of his or her health, HIV education programs need to start with the accepting statement, "of course." Of course survivors and victims engage in behaviors that are learned responses to past and current abuse. Acceptance means understanding that many of these behaviors in the lives of survivors and victims ensure their survival. For example, alcohol and drugs may be used to numb the reality of what happened or is currently happening, and can be a protective behavior

against suicide or self-mutilation. One HIV-positive survivor told me that exchanging sex for money gave her the feeling of control over her body, and, at that time in her life, she remembers feeling that her self-esteem increased. In her words, "It was better than either giving it away or having it taken. I felt like my body was worth something."

HIV prevention education needs to avoid easy slogans. For example, "Using a condom is easy"; "If your partner won't use a condom, than s/he's not worth it"; "If you are not old enough to talk to your partner, you're not old enough to have sex." Survivors and victims carry a tremendous amount of guilt and shame that is intensified by messages that contradict their reality. Using a condom is not easy if you fear touching your own body or someone else's. It may not be "worth it" to fight over a condom with a partner in a relationship that is non-consensual. A teenager who is forced to have sex may not be able to "talk to his partner." In most cases the adult perpetrator convinces the victim that the sexual abuse is consensual and the victim's fault. Victims and survivors who have not identified the abuse, or are currently being abused, may hear simple safer sex slogans as indictments of their behavior.

Adapting HIV and Prevention Education

We need to acknowledge and affirm the feelings and behaviors of survivors and victims of sexual abuse and non-consensual sex within our education programs. We need also to review the current ways we teach HIV disease and ask, "What is this process like for the survivors and victims in this group?"

"Simple" skill building exercises like teaching people how to put a condom on a penis can be difficult for some survivors and victims. "Negotiation" role plays and activities exploring the names and types of sexual activity can also be difficult. Additionally, forced exercises — like matching individuals together for an activity — can be threatening for individuals who do not feel comfortable saying "no" or stating their needs. Finally, most exercises and activities contain an assumption that participants can both process and feel at the same time. One survivor told me, "It's later, after the fact, that I'm confronted with the feelings, and they can be full of self-doubt and self-abuse."

Incorporating sexual abuse and non-consensual sex into HIV education efforts requires modeling and accepting small, manageable steps that match the individual's feelings and behaviors. This kind of work is similar to individual risk reduction counseling. Individuals in the groups I teach often say that they feel "safe" and "included." Some begin to make connections for themselves about how best to prevent HIV infection. One workshop participant "ran away" from a current relationship. Another requested a referral to start therapy. One 12 year-old girl wanted information about HIV antibody testing and counseling because she had been sexually assaulted by an adult male acquaintance. For some participants making the connections may mean taking home a condom or latex barrier and practicing with it. While many individuals disclose that they are survivors or victims after

or during HIV prevention education classes, many do not. The goal of this work is to help individuals identify their own risk behaviors for HIV, and not to label individuals as survivors or victims.

Effective education and prevention approaches must be based in the survivor's and the victim's perceptions of personal feelings, sexual experiences, and behaviors. HIV education must begin by addressing the discrepancy between the goals of current prevention education (perfect communication, perfect safer sex practice, perfect comfort with sexuality) and the abilities of survivors and victims of sexual abuse and non-consensual sex. When the reality of feelings, sexual experiences and behaviors is not affirmed or acknowledged, survivors and victims of abuse can leave an HIV education program feeling more powerless than before, feeling more isolated and different. They may leave less likely to utilize critical prevention information. The challenge is to acknowledge the protective value of behaviors in which survivors and victims engage, while gently assisting an understanding that those behaviors can lead to a risk for HIV infection. It is not hopeless. Survivors and victims are tremendously resourceful. It is simply recognizing, where, as HIV prevention educators, we need to begin.

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¹ Davis, L. *Allies in Healing* (New York: Harper Collins), 1991.

² Haffner, D. "Youth Still at Risk, Yet Barriers to Education Remain." SIECUS Report, Vol 21, No. 6 October/November 1992.

Cathy Kidman, a survivor herself, worked in domestic violence and rape prevention before joining the staff of The AIDS Project in Maine.

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FROM THE PRIVATE FAMILY DOMAIN TO THE PUBLIC HEALTH FORUM

Sexual Abuse, Women and Risk for HIV Infection

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An unprecedented increase in drug use among women in the last decade has been complicated by the troubling threat that HIV infection poses to those who engage in high-risk drug use and sexual behaviors.¹ The U.S. Department of Health and Human Services estimates that women are the fastest growing population infected with HIV. Women now comprise 11% of the nation's 241,146 AIDS cases, up from 4% in the mid-1980s.² In New York City, women comprise 16% of the 43,439 AIDS cases and in 1992, encompassed 20% of the 6,013 newly reported AIDS cases.³ Twenty-nine percent of the 912 AIDS cases reported among 13-19 year olds were female. Among 20-24 year olds, 18% of 9,270 cases were women.⁴

Researchers have identified two primary risk factors for HIV transmission among women: unsafe injection drug use and unprotected heterosexual contact. Nationally, the CDC reports that unsafe injection drug use accounts for 50% of all AIDS cases among women, and heterosexual contact accounts for 36% of these cases.⁵ In New York City, injecting drug use is identified as the major risk factor in 60% of all female AIDS cases, while sexual transmission from men at risk accounts for 25% of such cases.⁶ Therefore, it is critical that women's drug use and associated behaviors be addressed in order to curb the growth in HIV transmission among women.

This decade has witnessed substantial increases in women's drug use, marked by the use of crack as reflected in the mortality and morbidity rates.⁷ New York State reported that women made up a larger percentage of this crack-addicted population than any other addicted population.⁸ In New York City, maternal drug use (defined as the number of live births per thousand in which illicit drugs were mentioned on the birth certificate) increased from 7.4 per thousand live births in 1980 to 31.1 per thousand in 1989.⁹ The associated high risk behaviors of drug use place women at higher risk for HIV infection. These behaviors include unsafe injection drug use (sharing works and not using bleach to clean works). High risk behaviors in drug-using women also include sex-for-

drug exchanges and unprotected sexual intercourse. Sexual abuse rates among chemically dependent teenage and adult women are estimated to range from 28% to 56%.¹⁰ Female sexual abuse survivors are found to be much more likely to engage in prostitution and sex for drug transactions.¹¹

Sexual Abuse as Risk Factor for HIV Infection

Preliminary epidemiological investigations identify sexual abuse as a risk factor for HIV infection.¹² A history of sexual abuse in women has also been linked with the high-risk drug associated behaviors that place them at increased risk for becoming HIV-infected.¹³ This association between sexual abuse and subsequent high-risk drug taking and sexual behavior is demonstrated in our study of crack/cocaine dependent women reported in this article.¹⁴ Another recent study reports that women with sexual abuse histories are more likely to engage in sex work, to change sexual partners more often, and to have sexual intercourse with casual acquaintances than women who were never sexually abused.¹⁵ This research also indicates that children who were sexually abused at an early age, with greater frequency, and for longer durations, have higher rates of criminal incarceration, earlier drug use, sexual abuse by different perpetrators, and participation in sex-for-drug exchanges.¹⁶ All of these factors are independently associated with an increased risk for HIV infection.

Data on Sexual Abuse Prevalence

Recent epidemiological surveys estimate that 20% to 25% of women in the general population have a history of sexual abuse.¹⁷ A national study conducted in 1992 of 4,009 randomly selected women found that 61% of all reported rapes occurred before the victim reached age 18.¹⁸ According to the survey, 29% of all rapes occurred when the victims were younger than 11 years old. The survey found that 683,000, or 0.7%, of adult American women were raped during the twelve-month period prior to inter-

view. Significantly higher rates of rape are reported among chemically dependent women.¹⁹

Most women do not readily disclose histories of sexual trauma unless specifically solicited and unless a level of trust has been established with the clinician or researcher. The stigma associated with sexual abuse often contributes to underreporting of sexual victimization. One study emphasizes that the tendency to conceal sexual victimization is particularly strong for those abused in childhood, especially if they have previously confided in a trusted person and were not believed.²⁰

Even as research findings continue to confirm the association between sexual abuse and HIV infection, government assessment instruments used for the collection of crime statistics fail to directly address childhood sexual abuse, domestic violence, or other intimate forms of violence that are perpetrated principally by men against women and children. Although professional resistance to recognition of sexual abuse has started to break down, substantial disagreement on the definition of sexual abuse continues to exist, impeding the collection of accurate prevalence data. Insufficient data collection and the lack of a consensus about the definition of sexual abuse have inevitably led to underreporting and augmented risk for the neglected survivor.²¹ At one end of the spectrum unwanted petting and fondling are considered childhood sexual abuse; at the other end, sexual abuse is defined only as violent rape. A more precise definition of sexual abuse is clouded further by studies that seem to focus only on incest to the exclusion of extrafamilial sexual abuse. Still other studies blur the lines between childhood sexual abuse and physical abuse, creating methodological inconsistencies.

The need for greater awareness by public officials of the short-term and long-term risks of rape and sexual abuse is intensified by the enormity of the HIV/AIDS epidemic. Despite a greater demand for public health education services from rape survivors, clinical and public health response to the risk of acquiring HIV as a result of rape have lagged behind. A national study indicated that recent rape victims (assaulted within the five years prior to interviews) were four times more likely than victims of less recent rapes to be concerned about contracting HIV/AIDS. Although most rape survivors understand how HIV is transmitted and the risks of HIV infection, more than seven out of ten rape victims (73%) reported that no information about testing for exposure to HIV/AIDS was given at the time of the rape. Twice as many victims interviewed for the 1992 study were concerned about the development of sexually transmitted diseases (49% vs. 19%) than women who were raped five years prior to the interview.²²

Consequences of Sexual Abuse

Women with sexual abuse histories frequently have been found to display self-destructive behavioral and psychological patterns. These may include feelings of worthlessness, suicide, suicidal attempts, isolation, emotional numbing, and increased exposure to violence and revictimization.²³ An increasing body of literature suggests that sexual abuse may make one psychologically vulnerable to substance abuse.^{24,25} However, an alternate ideology exists which asserts that drug use may be a

mechanism to enhance self-esteem. In fact, several investigators argue that drug use decreases negative affect and/or increases positive affect and is therefore used as a coping strategy to deal with chronic stressors,²⁶ including the extreme stress experienced by traumatized survivors of sexual abuse.²⁷

Some sexual abuse survivors are at increased risk for a host of negative outcomes. Several researchers suggest that trauma associated with sexual abuse is a risk factor for the later onset of psychological disorders including post traumatic stress disorder (PTSD).²⁸ A national study of adult women reports that rape victims with PTSD are 5.3 times more likely to have two or more major alcohol-related problems (20.1% vs 3.8%); and 3.7 times more likely to have two or more serious drug-related problems (7.8% vs. 2.1%) compared to rape victims who do not suffer from PTSD. Rape victims with PTSD are 13.4 times more likely to have two or more major alcohol problems than women who had never been crime victims (20.1% vs. 1.5%); and 26 times more likely to have two or more major serious drug abuse problems (7.8% vs. 0.3%).²⁹

Mothers and Crack Study Finds High Prevalence of Sexual Abuse

Because of the dramatic increase in drug use among women of childbearing age and the inadequate response from the public health policy and treatment communities, we undertook a study to describe the characteristics of crack/cocaine use in women and to understand their drug treatment needs. We conducted this study based upon face-to-face interviews with 146 indigent drug-using women in New York City. To be eligible for inclusion in

RESEARCH NOTE

On a related topic, the most recent *AIDS and Public Policy* published an article called "Assessing Risk in the Absence of Information: HIV Risk Among Women Injection Drug Users Who Have Sex with Women" by Rebecca Young, Gloria Weissman, and Judith B. Cohen.

The authors assert that AIDS research and education programs have left lesbian injection drug users (IDUs) and other women IDUs who have sex with women without adequate assistance in accurately assessing their risks for HIV and AIDS.

Research suggests that lesbian and bisexual IDUs are not adequately reached by programs targeting other groups of injectors, or, if they are reached, are given incomplete and often conflicting information about level of risk for HIV infection and appropriate risk-reduction behaviors.

Since new evidence suggests that lesbian and bisexual IDUs may actually be at *increased* risk for acquiring HIV infection (when compared to exclusively heterosexual female IDUs), the impact of sexual abuse on lesbian communities clearly merits research attention. — *The Editor*

the study women had to be: 1) current users of crack/cocaine or have used crack/cocaine within the past three years, 2) currently pregnant and/or, 3) the mother of a pre-school age child.

The women were recruited from a variety of treatment and non-treatment sites in New York City: methadone maintenance treatment programs (which report that between 35% and 55% of methadone clients are using crack/cocaine); therapeutic communities; drug free outpatient programs; acupuncture treatment centers. Additionally, graduates of treatment programs were recruited. The non-treatment sites included outreach programs; homeless shelters; post-partum units; prenatal clinics and jails.

Seventy-four (51%) of the women interviewed reported having been victims of at least one forced sexual encounter. Fifteen of these women were victims of multiple or repeated unwanted sexual encounters, and 11 were victims of gang rape. Thirty-four (46% of this subsample) had been 16 years old or younger at the time of the assault. Fourteen of these women who were victimized in childhood had also been victims of incest. Fifty-one percent of the women who reported sexual abuse histories indicated that the abuse took place prior to the initiation of substance use.

Past sexual abuse was associated with experiences such as: psychiatric treatment, incarceration, and having had parents who were chemically dependent. Sexual abuse in these women was also associated with high-risk behaviors, including using drugs by age 15, having male partners who pressure them to use drugs during pregnancy, and engaging in sex-for-drug transactions. Women who had a history of sexual abuse were 2.9 times more likely to engage in sex-for-drug transactions than women who were not sexually abused.

Our study found sexual abuse histories to be strongly associated with drug-associated behaviors that put women at increased risk for HIV infection. The implication of our research is that therapy for recovery from sexual abuse trauma should be included under the rubric of drug treatment. Although literature now reports that self-medication with illicit drugs may be a response to PTSD, it is important to point out that other factors may cause drug use as well. The data also support that early negative experiences — including sexual abuse — can severely impair self-esteem. Crack use, however, may also increase the likelihood of adult sexual assault, which may further damage self-esteem and create a greater need for the esteem enhancement some women may derive by using crack. Thus a vicious cycle of causation is established.

Public Policy Recommendations

As a result of our study the following recommendations are made to address the rising drug use and existing sexual abuse among women, creating a subsequent risk for HIV infection:

- Accurate prevalence studies must be conducted in order to assess the extent of sexual abuse in women.
- Efforts to reduce the harm associated with drug use and high risk behavior for HIV infection must ad-

dress the interrelated experiences of drug addiction, sexual abuse, and male pressure to use drugs, in order to be effective.

- Comprehensive drug treatment — an approach that combines treatment for addiction with medical and therapeutic services for mothers and children — is necessary.³⁰ Sexual abuse is closely associated with chemical dependency; therefore, services addressing the abuse appears to be integrally related to recovery.
- A more comprehensive intervention that meets the needs of women will stop providers from labelling women as "resistant clients" and "treatment failures" because they will address the relevant issues more fully.³¹
- Effectively treating sexual abuse trauma and its associated consequences must be embraced as a critical piece of HIV/AIDS prevention.

Prevention, Gender Inequality and Correlates of HIV/AIDS

The unfolding HIV/AIDS epidemic among women requires educating women of all ages about the necessity of HIV risk reduction. However, it is imperative that the educational, treatment, and research communities also simultaneously focus on the boys and men who are often the perpetrators of the sexual violence. Therefore, prevention must begin by moving sexual abuse from the private family domain into the public health forum. Sexual abuse prevention cannot be considered exclusively a woman's treatment issue. Women must learn to protect themselves against possible perpetrators, but it is also necessary to understand what brings men to harm women.

Theorists contend that abusive patterns must be understood within the context of abusive power relationships within the family setting because these give men control over women and children. Consequently, researchers contend that violence against women and children in the family should be redefined as a social, rather than a private problem.³² While women and children are sexually abused on an individual basis, the problem is both chronic and widespread on a societal level. Social mores and underlying power issues must then be altered if sexual assault against women and children is to end.

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ASSUMPTIONS OF HIV/AIDS PREVENTION EDUCATION

Interviews with Gay Male Incest Survivors

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It is summer, 1990 when I interview Robert* about his experiences as an incest survivor. The air is hot, the noise of the busy street rises with the bus fumes to the window of his third-floor studio apartment. Unlike the others I've interviewed, Robert does not speak of his past easily. In fact, this is the first time he has talked about the abuse with anyone. His answers are short, frequently euphemistic, and he stares often toward a point in space I am never quite able to locate. Though he tells me he has a disability that has kept him out of work this past year, he does not mention HIV disease specifically. Even in this most confidential situation, Robert does not admit his seropositivity, much as in the past he has not spoken of his sexual abuse. One silence mirrors the other.

But this is not the time to push him. He flutters like a skittish bird as he relates the story of how his uncle forced him to have sex when Robert was 11 and things were particularly bad at home. A survivor myself, I know full well the pain this kind of questioning can elicit, and it seems clear that pushing him about HIV will mean he will draw back. Instead, we discuss Robert's volunteer work in AIDS organizations, his struggles with compulsive eating, his isolation from nearly everyone. In fact, the interview has been going for almost an hour before we get to the questions about the impact incest has had on his sexuality. I ask Robert if he feels he can negotiate in sexual relationships. "I like sex to be spontaneous," is his answer, but it is also something of a dodge. What I want to know is does Robert feel in charge of his own sexuality? Or, perhaps, more importantly, since we're living in an age of HIV/AIDS, can he say no to sexual intercourse when he doesn't want it? Is he able to set limits when someone wants to do something he considers an unsafe sexual activity?

"Usually I do whatever the other person wants the first time," he explains as he picks at the tattered Persian Rug. "After about the fourth or fifth time with someone, I'm able to say what I do and don't want to happen." I ask him if that means he's done things he thinks are unsafe. "I have, because I haven't been able to talk to people about sex. The little kid in me is frightened that the person I'm with won't accept what I want to do."

Robert's fear is not unusual; everybody wants to be ac-

cepted. Everybody has some difficulty feeling vulnerable in sexual relationships. However, incest survivors, in particular, know that not everyone can be trusted to take no for an answer. Of course, Robert is not the only gay man who has difficulty with safer sexual practices. "Relapse" or slipping back to risky sexual behavior due to complicated psychological issues, is a much-reported phenomenon. However, there is a difference between "relapse" and Robert's experience: to relapse implies that a person has successfully established a pattern of safer sexual behavior in the first place.

The Interviews

Robert's experiences are fairly similar to many of the gay male survivors interviewed for this article. In fact, several of the nine Boston-area men I interviewed try earnestly to practice safer sex, especially those who are in therapy. However, almost all of the men reported having had sexual intercourse that was unsafe, reported anal intercourse without a condom, and every one of them talked of feeling little or no ownership of his sexuality. Two of these men are HIV-positive, another two have AIDS, and two more — who described themselves as 'sexually compulsive' — reported they have not tested for HIV because they did not feel they could trust themselves with the results. These interviews took place in the metropolitan Boston area where the incidence of HIV infection among gay men is estimated to be at 20%. No statistical information exists to back up my anecdotal observations, since no comprehensive studies concerning the impact of child sexual abuse (or adult sexual abuse, for that matter) on the high-risk and health behavior of gay men have been conducted. It is clear, however, that the research should be conducted, since large numbers of gay male survivors of incest and other child abuse are not getting the support they need to employ safer sexual behaviors.

Incest, Feminism, and the Gay Male Community

There is a myth that incest survivors are an extremely small percentage of the gay male community. But one in six men (both homosexual and heterosexual) polled in a 1985 *Los Angeles Times* survey reported being sexually abused before the age of 18. Since phone surveys are

known to yield less-than-solid data, the statistic is probably underestimated. Additionally, many survivors block out the traumatic memories of abuse. Left with only the symptoms, many survivors are unable to identify themselves as such. While there is no reason to believe that the 15% figure is any lower in the gay male community than it was in the L.A. Times survey group, there are reasons to believe that a cohort of gay men only may yield a higher percentage of survivors. According to Mike Lew, the author of *Victims No Longer: Men Recovering from Incest and Other Sexual Child Abuse*, "Any little boy who departs from the way we expect little boys to be is more likely to be abused. People feel they have more license to behave more violently to a child who is different. By different I mean a [male] child who is gay, or appears to be gay, or effeminate, creative, artistic, academic, emotional."¹

Even though child sexual abuse has been around for centuries, it is only in the last decade or so that the subject has begun to receive significant attention. Such ground-breakers as *Father-Daughter Incest* (1981) *Voices in the Night: Women Speaking About Incest* (1982), and *I*

"Growing up, I always had the feeling that if I didn't have my body, none of this would have happened to me," Daniel says across his kitchen table. "The incest was my body's fault."

Never Told Anyone: Writings by Women Survivors of Child Sexual Abuse (1983), along with considerable feminist anti-violence organizing, have brought some light to the issue. (Interestingly, it is during this same time period that AIDS service organizations began to form. By and large, they were founded by men unaware of issues articulated by the feminist movement.) For the most part, though, incest and other child sexual abuse remains hidden, mysterious, and, in our culture, eroticized.

The slow but growing recognition of the abuse suffered by girls and women has not been translated into awareness of the sexual abuse of boys and men. Despite the statistics, the public face of the survivor remains female. America does not want to hear about the sexual abuse of men. Male sexual abuse victims challenge the central tenet of our society's institutionalized male supremacy. In addition, homophobia and society's confusion of rape with sexual intercourse, means that the abuse of boys and men by other men is deemed "homosexual," although the abuse of girls and women by men is rarely referred to as "heterosexual." Discussing the matter on any level is still taboo.

The feminist movement against sexual abuse has also articulated rape as a "women's" issue (although we actually assert it as a problem with the male perpetrators). Feminists have put forward an analysis which contends that rape is violence against women and that heterosexual men use the threat and practice of sexual violence against women and children as a guarantee of their privilege. In prioritizing the well-being of women, feminists have called on men to take responsibility for male violence and

additionally for helping to care for their abused peers. To change the popular and conception of sexual abuse as a "women's" problem, male survivors must stand up and utter what may well be the most difficult words in the world: "I was raped." So far, few have been willing to do so for several complicated reasons. Several survivors I interviewed believe gay men do not want to acknowledge the number of survivors in their midst because they fear the heterosexual world will use that information to further pathologize homosexuality. Gay men have struggled very hard, both before and after the beginning of the AIDS crisis, to free themselves from the dominant ideology of gay men as victims. Additionally, gay men have been scapegoated and inaccurately stereotyped as child molesters. Societal confusion between sexuality and violence has complicated the issues.

In order to understand the impact of child sexual abuse on HIV transmission in gay male survivors and on their health behavior, it is important to explore the following three factors: the general impact of child sexual abuse, the assumptions employed in gay-targeted AIDS education, and the specific impact of child sexual abuse on a survivor's ability to protect her/himself from HIV transmission.

The Impact of Child Sexual Abuse

The effects of incest and other child sexual abuse are devastating and complex, often resulting in tremendous psychic (and sometimes physical) pain. Because in childhood there is no opportunity to express this pain in a way that helps a survivor to heal, he or she learns to numb it by necessity. Of course, different people numb the pain in different ways. The survivors I interviewed became dependent on drugs or alcohol, some ate compulsively, had sexual intercourse compulsively, became insomniacs, workaholics, or masters at the art of becoming mentally absent (numbing). Many of the men in the interviews used several of these strategies, because sometimes one is not enough, and other times they needed new strategies to replace ones they had abandoned.

Survivors often isolate themselves because they have learned that being close to people is dangerous. Robert says, "I can feel more connected to people who I've seen, whose names I know, but who I don't actually know. I just think of them as close and intimate friends." Among survivors there is a strong, internalized sense of personal worthlessness. Ken weeps during the interview as he says, "My self-esteem is practically non-existent. The thing that bothers me most is not being able to believe that I'm a worthwhile person when people tell me that I am."

The body is not something we survivors do well with. In fact, we are hardly ever in them. Buck says, "I've had so little feeling that I've burned myself with liquid solder and watched my skin burn and not felt anything." Survivors often blame themselves for the abuse and for every other bad thing in the world. Survivors, having been abused by people in positions of authority, as adults often have trouble with authority. In addition, survivors experience the world as an extremely dangerous place. Survivors also often feel unprotectable and unworthy of protection. Additionally, self-punishment is a major component in the adult lives of survivors. Current psychological theory asserts that as children who are being abused find self-blame easier than believing the world is truly random, terrifying, and unsafe. Perpetrators and other family members often reaffirmed the survivor's guilt, reinforcing the ideas that

the child is really responsible because he or she is too seductive, too coy, too beautiful, too curious.

"Growing up, I always had the feeling that if I didn't have my body, none of this would have happened to me," Daniel says across his kitchen table. "The incest was my body's fault." Independently, both he and John speak of having sexual intercourse until it is painful, until it hurts them for days afterwards. This is how they punish themselves.

The Impact of Child Sexual Abuse on Gay Men Practicing Safer Sex

Will says, "There were times in my life when I really strongly felt I deserved no protection, whether it be from AIDS or violence or whatever. I can say that most of that came from incest. I was not protected. So it's difficult. You internalize that and say 'I'm not worthy of protection.'" Then he says: "We have always wanted our parents or some adult to put their arms around us, put a shield around us and say 'I'm not going to allow this to happen to you again. You're safe.' Unless we are willing to do that for ourselves mentally, it's going to be very difficult to put on a condom. Because a condom, in a way,

The "Just Do It" approach to HIV/AIDS education that has been tailored for gay men over the past eight years assumes empowerment, especially in the sexual sphere.

is what we always wanted — something to cover us and protect us."

Indeed, because survivors often experience themselves as unprotectable and undeserving, AIDS and incest become, in their minds, synonymous — the inexorable workings of the universe. "I believed that AIDS was going to get me no matter what," John says. "I didn't think there was anything I could do to stop it. Just like the abuse."

Survivors who do not have opportunities to confront their abuse employ complicated measures of coping with it — often by numbing out. This need to numb can result in high rates of sexual compulsivity, alcoholism and drug abuse among survivors. While these coping mechanisms may provide survivors with some protection from their memories, they may also increase the probability of contracting HIV infection.

For instance, many of the men I interviewed expressed that when they experienced emotions they could not manage, they went out to have sexual intercourse. Several described themselves as "sexually compulsive." Furthermore, studies show that gay men who combine drinking or drug use with sexual activity are significantly more likely to engage in unsafe sexual behavior.² Injection drug use by gay male survivors may allow another route of transmission, one not to be discounted, since it reportedly accounts for approximately 10% of all CDC-reported cases of HIV/AIDS among gay men. Unfortunately, many AIDS service organizations treat drug dependency as an irrelevant issue for gay male communities.

Some of the dynamics of unsafe sexual behavior were

not discussed by the men I interviewed. For instance, in the sexual arena, survivors interact with partners as if they are the parents they always wanted, who set limits and act in the survivor's best interest. Of course, survivors often become involved with people who are very much like the offending parents — neglectful, distant, or actively abusive. In these situations, the survivor may behave according to the feelings of being powerless children that originated from the time of the childhood sexual abuse. Survivors often wait for sexual partners to set the limits and then feel betrayed when the partners behave in ways that are particularly harmful or difficult. Protecting oneself from HIV transmission requires that a person take responsibility for setting the sexual limits. Unfortunately, this is often difficult for incest survivors.

Assumptions of HIV/AIDS Education

HIV/AIDS education that is targeted toward gay men in this country makes many assumptions that do not particularly fit survivors and their attitudes or beliefs. Most HIV/AIDS educational programs assume that:

- People attending HIV/AIDS workshops want to stay alive.
- All people feel entitled to health and believe that they will derive more benefits from staying well than from becoming ill.
- People feel some amount of ownership over their bodies.
- People know how to make choices and believe that making such choices will lead to successful changes in behavior.
- Most people are able to assert themselves and believe that their wishes, when expressed, will be respected.
- Most gay men attending an HIV/AIDS workshop have in common sexual intercourse as the primary risk factor for HIV transmission.
- The best educational strategy is one that depicts and discusses sexual behavior, but not the motivation behind that behavior.

The "Just Do It" approach to HIV/AIDS education that has been tailored for gay men over the past eight years assumes empowerment, especially in the sexual sphere. Indeed, for many gay men, these assumptions have held true, as demonstrated by the tremendous community response to this particular public health crisis. In fact, the percentage of men who are consistently practicing safer sex is relatively high, and the community can commend itself. However, one of eight respondents in a recent survey reported that they consistently participated in unsafe sexual behaviors in the six months prior to the survey.³ Empowered people make empowered healthy choices; disempowered people often do not.

John explains, "In the beginning of the AIDS crisis, I could have been more safe. I never put anyone at risk,

except myself. I knew I should not have been doing it, but I didn't want to live, I didn't want to participate in life any longer." Ken, a member of Sex and Love Addicts Anonymous, describes his feelings: "I knew that what I was doing was unsafe, or had unsafe potential, but I wasn't going to let that bother me. What mattered at that time was having sex." Buck adds that he was often using cocaine and could not negotiate safer sex. Will says, "I have difficulty [with negotiating safer sexual practices]. Like when I don't want to have it [sexual intercourse], I feel very much that I have to do it anyway. It's difficult because it has put me in some dangerous positions. Also, I think my own idea of sex was pretty dysfunctional. It's difficult to understand 'normal' sex when your first sexual experiences were based on violence."

Listening to these men, it is clear that the assumptions of AIDS education are not working for everyone. On a very basic level, survivors have had taken away the ability to assert boundaries and a sense of personal space and limits. Boundaries are no doubt an important component to establishing and practicing safer sexual behavior.

Shifting the Focus

Shifting the focus of AIDS education slightly, so that it incorporates discussions of barriers to safer sex behavior, is an essential part of meeting the needs of gay male incest survivors. It is important for all gay men — incest survivors or not — that AIDS educators create groups and workshops where men can talk about why they are having difficulty being safe. Slogans that address barriers to safer behavior may also be effective. John suggests, "Everybody needs to know that unsafe behavior says a lot about how you feel about yourself. People need a chance to say 'Why am I doing this?' 'Why am I feeling so unloving of myself that I don't want to protect myself?'"

Building a sense of self-esteem among survivors is key in making HIV/AIDS education work. Buck says, "I've been in situations where I haven't been safe and I guess I need to hear that I am important enough to protect. I also need to learn why I am having sex. Sometimes my self-esteem is really low and that is why I go out to have sex."

Survivors have also proposed that AIDS service organizations use slogans that can help us feel better about ourselves, like "Safer Sex — I'm Worth it!" in addition to the popular "Safer Sex — Do It!" HIV/AIDS educators can also encourage men to understand and assert their sexual boundaries. For survivors, learning to say "no" is the first step toward being able to say "yes." To sensitize staffs, AIDS service organizations can also offer in-service trainings about incest and its impact on unsafe sexual behaviors and other high-risk behavior, both to professionals and to peer-educators. Above all, HIV/AIDS educators should operate under the assumption that there will be survivors — self-identified or not — in every group and training. Trainers will, therefore, need to incorporate what they know about the impact of child sexual abuse into all of their work. Educators can create a safe space in generic workshops for survivors by allowing time to talk about sexual abuse and other sexual violence and its impact on high-risk behavior.

To reach those survivors who do not attend work-

shops, AIDS organizations may consider adapting brochures, comic books, videos and other educational materials to meet the needs of the survivors in their communities and target audiences. On-going groups and hotlines may consider trainings as well. In this kind of work, it may be important to have self-identified survivors on advisory committees. These steps can mount an important force in helping the gay male community begin to discuss the effect of child abuse on gay men's lives in the age of HIV/AIDS. It may be unrealistic to believe that all gay male survivors can be reached with these strategies. (Not every survivor feels safe enough to participate or to identify.) Neither should HIV/AIDS organizations alone be responsible for creating an atmosphere that encourages men to confront their sexual abuse histories. Nonetheless, these changes in strategy are a crucial part of helping gay male incest survivors address their problems with safer sexual behaviors.

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Author's Notes

* The names of the men interviewed for this article have been changed.

¹ Personal Communication, Lew, M, 1990.

² Stahl R et al. "Alcohol and Drug Use During Sexual Activity and compliance with Safe Sex Guidelines for AIDS: The AIDS Behavior Project." *Health Education Quarterly* 13:359-371, 1986.

³ AIDS Action Committee of Massachusetts. *A Survey of AIDS-Related Knowledge, Attitudes and Behaviors Among Gay and Bisexual Men in Greater Boston*. 1991.

FOR MORE INFORMATION

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Allies in Healing: When the Person You Love Was Sexually Abused as a Child, by Laura Davis, HarperCollins, 1991.

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SIECUS Fact Sheet

On Comprehensive Sexuality Education

GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION: KINDERGARTEN - 12TH GRADE

Most parents support sex education. But the gap between what they want and what schools deliver is wide, mainly because there is no agreement on what the curriculum should contain. The Sex Information and Education Council Of the United States (SIECUS) has now published guidelines that could lead to a consensus.

—New York Times, Opinion-Editorial page, October 18, 1991

The concepts in the Guidelines incorporate such universal values as respect for oneself and others, trust, and honesty and are built on a foundation that recognizes the importance of sexuality education to the well-being of our youth, now and in the future.

—Brenda Greene, Manager of the National School Boards Association, AIDS Education Project, School Board News, October 29, 1991

What are the *Guidelines For Comprehensive Sexuality Education: Kindergarten Through 12th Grade*?

The *Guidelines* are a comprehensive model designed to promote and facilitate the development of comprehensive sexuality education programs nationwide. The *Guidelines* are designed to provide a framework for developing comprehensive sexuality education curricula, textbooks, and programs as well as for evaluating existing programs.

Why were the *Guidelines* developed?

- Approximately nine out of ten parents want their children to have sexuality education in school.¹
- Seventeen states require sexuality education, and 30 others encourage it.²
- Only one-fifth of sexuality education curricula used by state education departments of education provide adequate sexuality information.
- Eight out of ten sexuality education teachers report a need for more assistance concerning education about prevention and sexually transmitted diseases.¹
- A literature search conducted by the SIECUS library revealed a lack of written material detailing standards for providing comprehensive sexuality education. National educational and public interest groups confirmed a need for guidelines for sexuality education.

How were the *Guidelines* developed?

In 1990, SIECUS, the Sex Information and Education Council of the United States, convened the National Guidelines Task Force to develop guidelines as a framework for providing sexuality education. The task force was comprised of 20 professionals in the fields of medicine, education, sexuality and youth services, from prestigious organizations such as the

American Medical Association, March of Dimes Birth Defects Foundation, Planned Parenthood Federation of America, National Education Association, American Social Health Association, U.S. Centers for Disease Control, and the National School Boards Association. This Task Force developed the topics, values, life behaviors, and developmental messages which are now presented as the *Guidelines For Comprehensive Sexuality Education: Kindergarten - 12th Grade*, a 52-page booklet. The National Guidelines Task Force authored the SIECUS published *Guidelines*.

What are the primary goals of the *Guidelines*?

The goal of comprehensive sexuality education is to assist children in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and help them acquire skills to make decisions now and in the future. The *Guidelines* define the life behaviors of a sexually healthy adult. The *Guidelines* are based on the following four primary goals:

- 1. INFORMATION:** To provide accurate information about human sexuality.
- 2. ATTITUDES, VALUES AND INSIGHTS:** To provide an opportunity for young people to question, explore and assess their sexual attitudes. A primary goal is to help young people develop their own values, acquire enhanced self-esteem, develop insights into their relationships with members of both genders, and to better understand obligations and responsibilities to themselves and others.
- 3. RELATIONSHIPS AND INTERPERSONAL SKILLS:** To help young people develop interpersonal skills, including communication, decision-making, peer refusal and assertiveness skills which will allow them to create satisfying relationships.

- 4. RESPONSIBILITY:** To help young people develop the ability to exercise responsibility regarding sexual relationships. This will include addressing issues such as abstinence, resisting pressure to become prematurely sexually involved, and using contraception and other measures related to promoting sexual health and well-being.

What are the key concepts of the *Guidelines*?

The *Guidelines* consist of six key concepts. These concepts encompass the components of a broad definition of sexuality. The key concepts are as follows: Human Development, Relationships, Personal Skills, Sexual Behavior, Sexual Health, and Society and Culture. Each key concept is designed in instructional levels reflecting four stages of development:

Level 1: Middle Childhood, (ages 5 through 8); early elementary school

Level 2: Preadolescence, (ages 9 through 12); upper elementary school

Level 3: Early Adolescence, (ages 12 through 15); middle school/junior high school

Level 4: Adolescence, (ages 15 through 18); high school

Are the *Guidelines* based on values?

The *Guidelines* are based on specific values related to human sexuality. The Task Force that developed these *Guidelines* did so in order to be consistent with values that reflect the beliefs of most communities in a pluralistic society. These values include:

- Sexuality is a natural and healthy part of living;
- Sexuality includes physical, ethical, spiritual, psychological, and emotional dimensions;
- Sexual relationships should never be coercive or exploitative;
- In a pluralistic society like the United States, people should respect and accept the diversity of values and beliefs about sexuality that exist in a community;
- Abstaining from sexual intercourse is the most effective method of preventing pregnancy and STD/HIV;
- All sexual decisions have effects or consequences;
- Individuals and society benefit when children are able to discuss sexuality with their parents and/or other trusted adults.

What is the philosophy underlying the *Guidelines*?

The *Guidelines* are based on the beliefs that sexuality education should be offered as part of an overall comprehensive health education program; that sexuality education should be taught only by specially trained teachers; that the community must be involved in the development and implementation of the program; that *all* children and youth will benefit from comprehensive sexuality education; and that all three learning domains – cognitive, affective, and behavioral – should be addressed in sexuality education programs.

How are the *Guidelines* structured?

The *Guidelines* are divided into 36 topics which make up a comprehensive sexuality education program. Each topic is broken down into developmental messages that are age-appropriate according to school level. There are 703 developmental messages for children and youth about sexuality included in the *Guidelines*.

How are the *Guidelines* being used?

Nearly 10,000 copies of the *Guidelines* have been distributed. The following are some specific ways in which the *Guidelines* are being used by individuals, community based organizations, and educational systems. As this guide was created for national distribution, each locality is customizing the material in the *Guidelines* to suit their needs.

- To develop new, and evaluate existing, programs.
- For discussion with school policy makers.
- For teacher/staff training.
- To develop new guidelines and evaluate existing ones.
- For peer education training.
- For classroom teaching at the college level.
- For parent education.
- For special education.
- For community education.

Who has endorsed the *Guidelines*?

The *Guidelines* have been endorsed by a number of national youth serving organizations, including:

American Association of Sex Educators
Counselors and Therapists
The Association of Reproductive Health Professionals
The Center for Population Options
Coalition on Sexuality and Disability
Girls, Incorporated
Midwest School Social Work Council
National Education Association
National Network of Runaway & Youth Services
Planned Parenthood Federation of America
Society for Behavioral Pediatrics

How can the *Guidelines* be purchased?

The *Guidelines* can be purchased by sending a check or money order for \$5.75 to:

SIECUS,
Publication Department
130 West 42nd Street, Suite 2500
New York, New York 10036
(212) 819-9770, fax: (212) 819-9776

References

1. Donovan, P. *Risk and Responsibility: Teaching Sex Education in America's Schools Today*. (New York: The Alan Guttmacher Institute, 1989), p. 5-6.
2. de Mauro, D. "Sexuality Education 1990: A review of State Sexuality and AIDS Curricula." *SIECUS Report*, 18 (2): 1-9, December 1989/January 1990.

This SIECUS Fact Sheet was compiled by Yvette Adams,
Guidelines Program Coordinator

ASSESSING THE GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION

Since the October 1991 release of the *Guidelines for Comprehensive Sexuality Education: Kindergarten Through 12th Grade*, SIECUS has received nearly 10,000 requests for the publication from around the country. The *Guidelines* are a framework for implementing comprehensive sexuality education from kindergarten through the 12th grade. With the continued support of the Carnegie Corporation of New York, SIECUS has launched a new project to assess how school systems, community-based organizations, and state and local education agencies are using the *Guidelines*. This December, nearly 200 surveys were distributed to institutions which had requested five or more copies of the publication, in order to evaluate the impact and implementation of the *Guidelines* in the development or evaluation of comprehensive sexuality education programs. More than half of the 22-question surveys were completed and returned for evaluation. Of those responding to the survey, 41% were from educational systems (such as school districts, universities, and educational institutions), and 33% were from community-based organizations.

Uses of the *Guidelines*

It is evident from survey responses that the *Guidelines* have become a vital training tool in educational systems and community-based organizations. Of the respondents, 44% distributed the *Guidelines* to other affiliated organizations and agencies for informational use. One-third of the respondents used the *Guidelines* as a reference document, and 45% used them in discussion with school policy makers.

Forty-one percent of respondents used the *Guidelines* to develop new programs, and 40% used them to evaluate existing local programs. Forty-nine percent of the purchasers used the *Guidelines* for additional curriculum and material development. The concentration of these programs were for pre-adolescents and early adolescents. Additionally, 46% of the respondents used the *Guidelines* for teacher training, and 37% used them for training other types of staff. An additional 11% of the respondents used the *Guidelines* for peer education training.

Sexuality Topics in Demand

The *Guidelines for Comprehensive Sexuality Education* cover 36 topics that must be included to make sexuality education truly comprehensive. Survey respondents were asked to indicate which of the topics they most valued in implementing or assessing their own programs. A breakdown of those topics is as follows:

- 40-49% used Sexual Identity & Orientation, Abstinence, Sexually Transmitted Diseases & HIV.
- 30-39% used Reproductive Anatomy & Physiology, Reproduction, Puberty, Families, Love, Dating, Values, Decision Making, Communication, Assertiveness, Sexual Abuse, Reproductive Health, Gender Roles.

- 20-29% used Body Image, Parenting, Marriage/Lifetime Commitments, Negotiation, Sexuality Through Out Life, Shared Sexual Behavior, Human Sexual Response, Abortion, Sexuality & Society, Diversity.
- Less than 20% used Finding Help, Fantasy, Sexual Dysfunction, Sexuality & Religion, Sexuality & The Law, Sexuality & The Arts, Sexuality & The Media.

A Community Catalyst for Healthier Education

The *Guidelines* have been an catalyst in community discussions and in determining how sexuality education should be taught. Schools are beginning to address the need to transcend mere discussions of reproductive anatomy and physiology and to provide instead a holistic exploration of sexuality, skills-building, and comprehensive education. In addition, HIV/AIDS educators are beginning to address the need for their workshops and classes to fit into an overall sexuality education program. In one school, where the *Guidelines* were taught, students wrote and circulated a petition that requested more sexuality education. A county medical society used the *Guidelines* as a reference document to produce a continuing medical education seminar dealing with youth and sexual behavior. Parents in many communities where the *Guidelines* are being employed, have pointed out the need for sexuality education for parents. In many communities discussions on the *Guidelines* have brought parents, teachers, administrators, community and religious leaders and school board members together to discuss educating young people in a healthy, holistic way.

Technical assistance was requested of SIECUS in the areas of training, library information, and curriculum selection information. Survey respondents also indicated the need for a fact sheet on the *Guidelines*; support articles on age-appropriate sexuality education in the SIECUS Report; compilation reports on specific topics, concise relevant scientific support for policy position statements; a network of existing comprehensive sexuality education programs in different communities; and research data to support age-appropriateness and the development levels.

Controversies and Change

While the *Guidelines* are a vital conceptual framework to assist in providing comprehensive sexuality education, there have been controversies concerning both its actual content and intent and its alleged content and intent. In fact, 21% of survey respondents reported controversies in their communities, usually about abstinence-only programs versus comprehensive sexuality education, or about when sexuality education should be taught.

The overwhelming response to the *Guidelines* has been encouraging. The *Guidelines* are being used to provide and improve comprehensive sexuality education across the country.

Written by Yvette Adams, Guidelines Program Coordinator.

THE SOCIAL IMPACT OF AIDS

Debra Haffner, MPH

Executive Director, SIECUS

My first reaction when I saw the article in the newspaper during my commute to the office was disbelief. Surely the headline in the February 5, 1993 issue of the *New York Times* couldn't read "Research Group Says AIDS Epidemic Will Have Little Effect on U.S." But it did. The Associated Press writer began the story as follows:

Despite the thousands of deaths it has caused and the sense of national health emergency surrounding it, the AIDS epidemic will have little impact on the lives of most Americans or the way society functions, the National Research Council says. In a study made public today, the council said AIDS was concentrated among homosexuals, drug users, the poor and the undereducated, and called them 'socially marginalized groups' with 'little economic, political, and social power.' The chairman of the study, Albert R. Jonsen, was quoted as saying, "AIDS has devastated the personal lives and social communities it has touched, but the epidemic has little effect on American society as a whole or its way of doing business."

I felt enraged and stunned reading these words. On a personal level, I thought of how much AIDS has changed my own life, the friends and colleagues I have lost, and the people I know who struggle daily with the disease. I ached for the people with AIDS, their families, and their friends who are part of my life and how discounted they would feel reading these words.

I was equally disturbed professionally. Surely, the authors of the report could not be talking about New York City where the most basic institutions have been severely affected by the HIV/AIDS epidemic. I worried that the message about "socially marginalized groups" would strongly undermine the health education message that it is behavior that places one at risk, not group status. I thought how easy it would be for many people to revert to unsafe sexual behaviors now that the Research Council had announced they would not be affected. I imagined the Far Right, busily reprinting the article to show that the threat of AIDS was exaggerated, and there was no need to support education, research, and treatment.

When I reached the office, I asked that we call the National Research Council of the National Academy of Sciences for a copy of the press release, a list of panel members, and a copy of the report. The press release, it turns out, did mirror the Associated Press article. It stated, "There is little evidence that six major American social institutions have been changed fundamentally....Few Americans are infected....There have been few structural

changes in the health care financing system....No fundamental changes in the ways in which health care is delivered in prisons....[And] very little effect on religious groups as a whole." I shook my head as I read the list of panel members, who include some of the most dedicated AIDS professionals I know.

What the Report Says

I decided to suspend judgment until I received and read the 322-page report. As I had begun to suspect, the book bore little resemblance to the press releases and news reports. The book jacket itself reads, "As many as one million people in the United States may be infected with HIV, the virus that causes AIDS, but its ultimate impact will extend far beyond those individuals and their families...the nation will confront AIDS and its consequences for years." The report is a study of the impact of AIDS on the following social institutions: public health, health care delivery and financing, clinical research and drug regulation, religion and religious groups, voluntary and community-based organizations, and correctional systems. The authors also conducted an in-depth assessment of the impact of AIDS in New York City. Far from addressing all social institutions, the report concentrates on these six.

The study reports such significant impacts on the HIV/AIDS epidemic:

- On public health practices, "The impact of the epidemic has been pervasive: It has prompted a critical examination of traditional responses." (p. 10)
- On health care, "AIDS is the most profound challenge to the care of patients that has faced the health care provider community in modern times." (p. 12) "AIDS presents a major challenge to hospitals, nursing homes, physicians, nurses, and other direct providers of health care services." (p. 48)
- On clinical research, "Patient activism and the exigencies of the AIDS epidemic have generated the most significant re-evaluation of the research and regulation process to occur since World War II." (p. 14)

In direct contradiction to the press stories, the report discusses in great detail how dramatically these institutions have been affected. The report demonstrates a dedicated compassion and concern for people with AIDS that the press belied. The report also charges U.S. social

institutions with inadequate responses to the challenges of the epidemic. The authors report:

Our most general conclusion about the epidemic is that its impact has hit institutions hardest where they are weakest: serving the most disadvantaged people in U.S. society. (p.8)

A constant theme of this report...is the stigma, discrimination, and inequalities of the AIDS epidemic. At its outset, HIV disease settled among socially disadvantaged groups, and as the epidemic has progressed, AIDS has increasingly been an affliction of people who have little economic, political, and social power. (p.8)

The report dramatically illustrates how poorly political and social institutions responds to those perceived to be without power.

I cannot help but wonder if the author of the press release had read the report. Clearly, many of the reporters covering the story had not. Ironically, in the summary that is the introduction to the report, the panel warns about the need for policy makers to consider carefully how information in the epidemic is shared:

A failure by scientists and policy makers to appreciate the interaction between social, economic, and cultural conditions and the propagation of HIV/AIDS disease has often led to public misunderstanding and policy mistakes about the epidemic. (p. 8)

If only the National Research Council had been as careful in developing its press strategy as they had been in the writing of the report.

The panel's study leader, Albert Jonsen, issued an editorial a month later entitled, "Will America Turn Its Back on AIDS?" He decried the misinterpretation of the report and stated that "in the light of the harsh realities of AIDS, we concluded that American institutions have not yet responded with the vigor and originality that the epidemic merits." Unfortunately, his editorial received scant press attention, although several op-ed pieces by conservatives have appeared urging readers to "re-think AIDS."

Impact of AIDS on Sexuality and Sexuality Education

Overall, the report offers some important new understandings about the nature of the HIV/AIDS epidemic. I was sorry that the panel had limited itself to investigating only six social institutions and did not address itself to many other important areas.

AIDS has had a major social impact on American schools, although education was not discussed. The impact of the epidemic on health education has been profound. Prior to the Surgeon General's report in 1986, only three states required sexuality education. Largely as a result of concerns about the epidemic, during the past six years, nearly every state legislature passed requirements or recommendations for sexuality and HIV/AIDS education. Condom availability programs may not have been implemented based solely on teen pregnancy and STD prevention. The current controversies over sexuality education, which focus on what should be taught, rather than if sexuality education should be taught at all, have

been influenced by AIDS. The only reference to sexuality education in the index of the report is "sex education, religious objections to." I think that most of us who were sexuality educators before AIDS became an issue could offer dramatic testimony to the increased interest in sexuality in state legislatures, school boards, classrooms, and homes as a result of the epidemic.

The report does not address the profound impact that AIDS has had on cultural and personal views of sexuality. There is no question that HIV/AIDS has played a major role in how Americans view and talk about sexuality. Prior to 1986, it was inconceivable that television programs and movies would depict condom use and conversations about condoms. The print media now regularly uses such language as anal intercourse, vaginal intercourse, and oral sex. Today's teenagers were small children when the AIDS epidemic began, and their entire understanding of sexuality is colored by the disease. Numerous popular studies have documented changes in people's attitudes as well as changes in behavior. I wonder if the front page coverage of issues of gay men and lesbians in the military would have happened without the increased efforts, organizing, and visibility of AIDS activists, who have helped to uncover homophobic responses to people living with the disease.

The question remains: Will AIDS have a lasting impact on America? At this stage in the epidemic it may be too early to know if future generations will be living with AIDS as we are. However, it is clear that AIDS has had — and will continue to have — a profound impact on the way we live and love, and the way too many of us will die.

BOOK REVIEWERS NEEDED

WANTED: Sexuality and health educators and other interested sexuality professionals to review books and videos on such topics as:

- Reproductive Rights
- HIV/AIDS Prevention Education
- Sexual Orientation
- Comprehensive Sexuality Education
- Censorship.
- Other Sexuality Topics

If you are interested in reviewing a book or video, please send your name, affiliation, particular specialty, address, phone number and fax number to:

SIECUS Book/Video Review Team
130 West 42nd Street, Suite 2500
New York, NY 10036
Or fax (212) 819-9776

• BOOKS • BOOKS • BOOKS • BOOKS • BOOKS • BOOKS

The Invisible Epidemic: The Story of Women and AIDS

by Gena Corea.
Harper Collins, 356 pp, \$23.00

Picture someone with AIDS. Who comes to mind? A white gay man? A male drug addict? Most people do not picture those who are today the fastest-growing population in the AIDS epidemic — women. AIDS is now the leading cause of death for African-American women of reproductive age in New York City and New Jersey. Nationwide, it is the sixth cause of death for all women. According to the World Health Organization (WHO), by the year 2000, women will make up the majority of newly infected people around the globe. Gena Corea has written a brilliant book detailing the individual stories of women with AIDS in the U.S. in *The Invisible Epidemic*.

As the Prevention Coordinator at the Chicago Women's AIDS Project, located

Corea builds her book on the understanding that socioeconomic structures have an enormous impact on the AIDS epidemic.

on the edge of Uptown (one of the poorest neighborhoods in the city), I have seen what most haven't. Uptown has the city's second-highest rate of HIV infection for women. Dozens of HIV-positive women and their families come to us each week. In a way, Corea's book is about our work. While sorrow is no stranger to us, we have never met the mythical "AIDS victim" who is a favorite media fiction. We know only women who are struggling to live with AIDS, to keep their families together, and to demand respect from a health and welfare system that so mistreats women as if they were only vectors of transmission to "innocent" children and men.

Corea's book contains a series of portraits based on interviews with women involved in the epidemic. Although the women are separated by gulfs of race, class, and geography, they are dragged into a vortex called AIDS. We meet, for instance, Lady T., a former kindergarten teacher, who became a streetwalker and pickpocket to support her habit and es-

cape from life into drugs. We meet Patricia, a newlywed from rural Maine, who may not have become infected had her husband's doctor thought to test him for HIV. We get to know Ada Setal, a grandmother who cares for and finally buries her daughter and her grandchildren. We meet doctors, researchers, social workers, and activists. If Corea's book has one fault, it is her tendency to level the impact of HIV, by giving the same importance to women living with the disease and women working in the field. In the real world, the frustration of a doctor whose grant does not get funded, although the implications are wide-ranging, is not as personally tragic as a single mother who dies, leaving four young children behind.

Each vignette reads easily, like the best fiction — rich, intimate, and moving. But Corea has done more than simply tell the women's stories. She has written the female equivalent of Randy Shiltz's classic, *And the Band Played On*, exposing that women with AIDS have been hidden by indifference to human life. Corea begins in the earliest days of 1981, when women just "got sick and died" for no apparent reason. In the background is a brooding sense of disaster: a deadly epidemic advances, while "experts" deny what is happening, and women, fighting to name and confront the disease are shut out. A researcher who wants to study AIDS in women is told by her boss to look for another job if she cannot find something less trivial to investigate. The newlywed, who later turns out to be HIV-positive, is scolded by her doctor when she keeps asking for an HIV-antibody test. "You're obsessing," the doctor tells her. "I think you just don't like being a woman."

As the story unfolds, each woman begins to come together with others, organizing, raising voices and fists, forcing an acknowledgement of what is happening. Ada Setal organizes a support group to advocate for caretakers of children with AIDS; women at Bedford Hill's Prison initiate a peer education program in opposition to AIDS hysteria and official neglect; researchers are pressured by activists to organize a national conference; women in ACT UP demonstrate, protest, and educate about the issue. Such dignity and power make this book inspirational.

Corea builds her book on the understanding that socioeconomic structures have an enormous impact on the AIDS epidemic. Largely overshadowed by individual behavior are the larger economic and political forces that impel the

poor and powerless toward risky behaviors, such as unprotected sexual intercourse and sharing contaminated needles. Shut out of legitimate employment, a sector of poor Black youth are disproportionately drawn into the lower tiers of the drug trade, with devastating consequences. Such social forces increasingly push the "second wave" of the epidemic into poor communities of color. To change individual behavior we need to radically change the underlying conditions that accommodate infection: poverty, racism, unemployment, the lack of access to health care.

Corea deeply probes the relationship between women, drugs, and violence. Today 75% of women with AIDS in the United States were infected by their own unsafe use of injecting drugs or by unsafe sexual behaviors with drug-using partners. Through her interviews, Corea reveals how street drugs and alcohol are used as a form of solace, as self-medication to help the poor and marginalized to cope with life on a dead-end street. The drug use also seems associated with women who are survivors of sexual abuse and incest. The drugs that begin as a solace become a terrible master: for many women, supporting a habit requires the selling of everything, including one's body; in turn, being violated at such a deep level often leads to more drugs to dull the pain. For all the talk of a "war on drugs" current policy offers little help for women who seek escape in this downward cycle.

Corea points out that one of the secrets about AIDS is that "gender behavior — how men treat women — is a major factor in the spread of AIDS." Consider the fact that battering is the single greatest cause of injury among women in the United States. In such an environment, coerced (unprotected) sexual intercourse — rape — is an ordinary occurrence. AIDS hotlines report an increasing number of calls from women who report assault after they suggest using condoms with their partner.

Corea's book points out how the AIDS epidemic is like a prism. If we pass a light through, we can see what is often invisible. Passing a light through the prism of AIDS, Corea reveals sexism, racism, the breakdown of public health systems, failure of policy and leadership. She has also shown us women working courageously to overcome overwhelming obstacles.

Reviewed by Vicki Legion. Legion is the prevention coordinator of the Chicago Women's AIDS Project.

• AUDIO-VISUALS • AUDIO-VISUALS • AUDIO-VISUALS •

People Like Us, 1992, 40 minutes, \$125.00.

Sex, Condoms, and Videotape, 1992, 26 minutes, \$200.00.

Both tapes available from the University of Connecticut AIDS Risk Reduction Project, 203/486-5060. (\$200.00 to purchase both)

People Like Us presents six young people in their late teens to late twenties talking about their childhoods and families, dreams and desires, and the impact that HIV infection has had on their lives. Speaking directly to the viewer—one at a time with no sets or props and a black background—are Kerry, Pedro, Christina, Paul, Beatrice, and Jim. They offer clear information to dispel the myths about risk groups and convince the viewer that "it's not who you are; it's what you do." A great deal of care and professionalism has gone into every aspect of the production—lighting, directing, sound recording, photography, and editing—to create a simple and accessible show.

Watching this video is like sitting across the table from each of these articulate people, listening to their stories. The value of education, family, and helping others is a theme of the interviewee's introductions. Each speaker starts by telling how his or her diagnosis with HIV/AIDS has changed plans and relationships. "I always wanted a family." "I wanted to be a doctor." "My dream was law school and politics." The implication is that these dreams are dead. One speaker, in particular, is more direct: "You lose everything."

Each in turn discusses the denial or ignorance and misconceptions that led to HIV infection. Kerry: "No one ever told me that as a 15-year-old kid I could end up with someone who was infected. They were other people; they were gay men. And that's what I was told." Jim: "I didn't practice safe sex at all. If I knew then what I know now..." Christine: "Abstinence was...if you weren't having sex, people felt sorry for you."

The extent of illness is the last, and most draining, subject covered by the speakers: medications, side effects, and fears of what may come next. Beatrice: "One guy had a parasite in his brain. That...scared the hell out of me." Paul, who identifies as having "full-blown" AIDS, shows his Hickman catheter, implanted because "I cannot eat."

The video wraps up by presenting an introduction to issues of negotiating safer sex, answering objections partners may

have to condom use, and some techniques for eroticizing safer sex. This part is important but quite limited.

There are many important messages in this well-made video that make it a potentially valuable tool in the context of a larger educational program and in the hands of a qualified educator. People with HIV/AIDS are known to be particularly effective in convincing uninfected individuals of their personal risks. This video should promote compassion for people living with HIV/AIDS, an important goal of HIV/AIDS education. And it reminds us more than once that behaviors, not membership in any group, are risk factors.

The last section is somewhat perfunctory and could be left off in an initial viewing. In fact, the producers of this tape have produced a follow-up video dealing with behavioral skills. The specific information about medications effectively conveys the severity of HIV/AIDS and the problems of treatment, but AZT and ddI are incorrectly identified as drugs "that increase the immune system." Providing misinformation is a disservice to any viewer who is or will be involved in decisionmaking about health care for a PWA.

All of the women and one of the men identify as heterosexual. Paul tells us "I wasn't sure if I was gay. I played around both sides." Pedro obviously skirts the question. Five of the speakers are white and one is Hispanic. The producers may well have felt that addressing the subject of homosexuality was outside the scope of this tape and might prevent the messages from reaching the target audience—presumably a white, heterosexual, middle class, HIV-negative audience. But HIV/AIDS education provides a crucial opportunity to challenge homophobia and racism, and anyone using this tape needs to be aware of the need to address these issues in the context of an HIV/AIDS education program.

The strong connection made between sexual activity and disease could easily lead to sex-negative ideation. Educators should balance this potential problem by presenting sexuality in a healthy and positive light, especially for people with HIV/AIDS. Finally, the expressions of fear and sense of loss by the subjects are quite grim. To expand the understanding of people living with HIV/AIDS, students shown this video should hear from, in person, people who have coped with the initial reactions to diagnosis, have made decisions regarding treatment options, and are living productive lives. Fear may be an expensive educational

method, but it can never be as effective in the long run as hope.

In contrast, *Sex, Condoms, and Videotape* is a relatively light and amusing video featuring ten white suburban college students in a series of vignettes about practicing safer sexual behaviors. Their stories are interwoven, giving viewers brief glimpses of each throughout. This technique effectively creates suspense, or at least curiosity, about what might be coming next.

In the opening scene, we see some of the characters at a pharmacy, purchasing condoms. Their affects range from embarrassment to swagger. Subsequent stories are told in sections. Two young women discuss the concerns that one of them, Jackie, has about broaching the subject of condom use with her boyfriend, Brian. A young man is seen primping for a date, placing condoms in his pocket as a final touch. A couple observes a sexual pick-up at a bar, commenting humorously and eventually discussing their own lapses in using condoms. A young woman arrives at her boyfriend's dorm room where he initiates a brief and mutually amenable negotiation, but when the time comes to use them, no condoms can be found.

The most important message is that, although talking about safer sex with a partner can be scary and awkward, it can be accomplished successfully and sometimes playfully. A number of behavioral skills are modeled, and responses to some frequent safer sex objections are offered. Another significant message, offered twice in this video, involves situations where condoms seem to be unavailable. The students comment that "there are other things we can do." This is the extent of the sexually explicit content of the program. It is hoped that the tape will open discussion about a diverse range of expression that can be considered safer sex.

Sex, Condoms, and Videotape is well-suited to a number of adjunct educational techniques, including dialogue writing and role playing. Teachers can stop the tape during each story and ask questions, such as "What do you think will happen next?" or "What would you do?" Finally, this video may inspire some students to make their own videos exploring and incorporating the important questions and answers it raises.

Reviewed by Daniel Jacobs. Jacobs is a high school teacher, member of the AIDS Theatre Project, and a person living with AIDS. He is SIECUS' Membership Assistant.