

## AIDS Prevention and Civil Liberties: The False Security of Mandatory Testing

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Our nation is struggling to cope with the emergence of a tragic new disease, Acquired Immunodeficiency Syndrome (AIDS). Some of the responses to AIDS have included proposals for drastic curtailment of individual rights and liberties, purportedly to stop the spread of AIDS. In February 1987, the Centers for Disease Control (CDC), of the United States Public Health Service, convened a conference in Atlanta to discuss proposals for compulsory testing of various segments of the population—persons entering hospitals, marriage license applicants, pregnant women, and patients at family planning, drug abuse and sexually transmitted disease (STD) clinics. This memorandum presents the ACLU's position on these proposals and outlines the reasoning behind that position.

### ACLU Supports Voluntary Testing Programs

The ACLU (American Civil Liberties Union) supports widely available, voluntary testing programs, coupled with adequate counseling and the assurance of anonymity or, if that is not possible, strict protections of confidentiality.

The ACLU opposes tests for the AIDS virus which are forcibly imposed. Indeed, for each proposal for enforced testing under discussion, the ACLU believes that the less coercive policy of voluntary testing would work as well, or better. In some situations, civil liberties defects aside, mandatory testing seems destined to be counterproductive, irrationally wasteful of public funds, or both.

Most urgently, the ACLU demands that stringent new laws be enacted to protect the confidentiality of AIDS-related medical records and to prohibit discrimination based on test results, or AIDS-related conditions, or sexual orientation. Without these laws in place, public health efforts which are premised on securing the cooperation of persons affected by this disease are doomed. Additionally, federal and state governments must not be allowed to hide behind a smokescreen of debate on testing—a strategy of, at best, limited effectiveness—while abdicating their responsibility to educate and counsel all Americans on how to protect themselves and others from this disease.

### Background Facts About the Test

The blood tests currently available are designed to detect the presence of antibodies to the virus believed to cause AIDS (which is called the human immunodeficiency virus,

or HIV). Antibodies are generated when the body's immune system attempts to fight off the virus. Although the presence of antibodies is not the same as the presence of the virus itself, the correlation between the two is sufficiently high that antibody positivity is treated as equivalent to viral infection. Thus a positive antibody test result is interpreted to mean that one is infected with the AIDS virus and potentially can transmit it to others. HIV antibody test results do not predict whether one will develop AIDS itself, or other clinical manifestations of disease such as AIDS-related complex (ARC). Nor is one given different counseling about preventing transmission based on positivity or negativity—the advice for anyone infected or at risk of infection is the same: to engage only in safer sex activities and, if using drugs, not to share needles.

Testing is a two-part process. The enzyme-linked immunosorbent assay (ELISA) test is the initial screening test. The ELISA test is highly sensitive to HIV antibodies, so much so that its potential for error is to "overreact," resulting in false positives. The New York Blood Center has found that 1% to 3% of donors are repeatedly positive on ELISA tests, and 90% of those are negative on the confirmatory test.<sup>1</sup> A study conducted by the Atlanta Red Cross and the CDC in 1985 tested 61,190 units of blood, and found 569 to be initially reactive on an ELISA test, but only 171 to be repeatedly ELISA reactive. Of the 150 which were further tested, only 40 were confirmed as positive.<sup>2</sup>

The second step of the testing process is the confirmatory test. The primary confirmatory test is the Western blot test.<sup>3</sup> A positive HIV antibody result is not considered to be a true positive, unless it has been both repeatedly positive on ELISA and positive on the Western blot.

When this two-part protocol is followed, the test can be extremely valuable for some purposes, especially as a mechanism for screening blood or tissue from donors. That situation creates little harm from false positives because the worst outcome is that some blood or tissue is discarded unnecessarily. But in other uses of the test, its defects have much more serious ramifications.

There are several ways that this two-part testing protocol can produce errors. First, the tests miss some infected persons entirely. The tests may register negative in the early stages of viral infection, before the antibodies have been

sufficiently mobilized to show up as positive on an antibody test. This incubation period—the time between infection and antibody reaction—usually lasts about six weeks, but may last as long as six months, or more.<sup>4</sup> A negative test result therefore should not be considered a true negative unless it is later repeated as a negative, or unless there has been no possibility of exposure for several months preceding the test.

More importantly, however, it is crucial to understand that any test which is less than perfect will misidentify small percentages but significant numbers of people. The nature of the error—whether false positives or false negatives—will depend on the population tested. In a population where the true seroprevalence level is low (marriage license applicants of pregnant women, for example), the mistakes will tend to be false positives—most of the marginal cases identified as positive will in fact be negative. In a population where the true seroprevalence level is high (such as gay men in a large U.S. city), the mistakes will tend to be false negatives—the marginal cases will tend to be in fact positives, but some will be identified incorrectly as negative.

Studies of the accuracy of the combined ELISA-Western blot testing protocol are only beginning to be published. One study, by researchers at the Harvard School of Public Health, estimates that for a low-risk population (defined for this study as 0.03%, comparable to seroprevalence rates among blood donors), 72% of the confirmed positives after both an ELISA and a Western blot test would be truly positive, and the other 28% would be false positives.<sup>5</sup> Another study, by a Wisconsin state epidemiologist, estimated that in a population with a true seroprevalence rate of 0.05%, 10% of those who test positive on both ELISA and Western blot would be false positives.<sup>6</sup>

Estimates of test performance in relatively high infection-level populations confirm that the primary risk there is false negatives. In a sample population of 100,000 persons with a true infection level of 30%, the Harvard study predicted 1,980 false negatives.<sup>7</sup> In the same size population, with a 20% seroprevalence rate, the Wisconsin study predicted 1,552 false negatives.<sup>8</sup>

Even these accuracy rates assume, however, that the test is performed properly. The accuracy rates of commercial laboratories offering the test may vary widely, including up to 20% false positivity rates on pre-tested samples.<sup>9</sup>

The potential damage from false positive test results is obvious—stigmatization, inclusion of one's name in a government-controlled list, unnecessary and severe emotional shock and, if the result becomes known, possible loss of job or insurance. The danger of falsely negative results is also serious. Those who think they are negative when in fact they are positive, and who rely on the test result as a "go-ahead" signal to engage in high-risk behaviors safely, are very likely to infect others.

The availability of the antibody tests, together with self-deferral by high-risk groups, has rescued the nation's blood supply by virtually eliminating the danger of HIV infection from receipt of a blood transfusion. The tests have made

possible important epidemiological studies to track the disease. They can also be a valuable tool in providing individual health care and in fashioning public health responses. But the existence of error rates, even if low, for both positivity and negativity, exacerbate the threats to civil rights and civil liberties which would result if testing were widespread and compulsory.

### The Harm Inflicted by Mandatory Testing

The legal framework for analyzing the constitutionality of proposals sought in the name of public health which curtail individual liberty is a balancing test which asks in essence these questions:<sup>10</sup>

1. What rights are violated, or what harm is caused, by the proposed government policy?
2. If fundamental rights are violated, or a discrete and disfavored group is singled out for less favorable treatment, is the state's interest or goal so compelling as to outweigh the harm imposed?
3. Even if the state's goal is compelling, will this policy be likely to achieve that goal, and are there other, less intrusive policies which could be used instead?

In some contexts, such as employment, the balancing model would be supplemented by statutory standards which are more precise.<sup>11</sup> This memorandum, however, focuses on the constitutional standards for analyzing mandatory testing proposals.

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## — PLAGUES AND PEOPLE —

“...CAUGHT IN THE COMPLEX WEB OF SOCIAL AND SCIENTIFIC QUESTIONS SURROUNDING AIDS...THE HIGH MORTALITY ASSOCIATED WITH AIDS AND THE GROWING NUMBER OF CASES COULD BECOME THE JUSTIFICATION FOR DRASTIC MEASURES. ‘BETTER SAFE THAN SORRY’ COULD WELL BECOME A CATCH PHRASE TO JUSTIFY DRAMATIC ABUSES OF HUMAN RIGHTS IN THE CONTEXT OF AN UNCERTAIN SCIENCE...ITS ASSOCIATION IN MUCH OF THE PUBLIC EYE WITH VIOLATION OF THE MORAL CODE COULD CONTRIBUTE TO SPIRALING HYSTERIA AND ANGER WHICH HAS ALREADY LED TO THE DOUBLE JEOPARDY OF LETHAL DISEASE AND SOCIAL OPPRESSION....AIDS WILL BE A MEASURE UPON WHICH WE MAY CALIBRATE...OUR CAPACITY FOR JUSTICE AND COMPASSION.”

— posted in large type on the outside wall of the Judson Memorial Church in New York City,  
August 1987. (Quotation is from *No Magic Bullet* by Allan M. Brandt.)

### A. Harms Imposed

A government plan to force Americans to undergo compulsory testing for the HIV antibody would be challengeable on a variety of constitutional theories.

First, simply imposing the test constitutes a degree of physical intrusion which, under the Fourth Amendment, the state has an obligation to justify by a showing of necessity and minimal harm. It is established law that an involuntary blood test constitutes a search and seizure within that Amendment's scope. *Winston v. Lee*, 470 U.S. 753 (1985). The state must demonstrate that this intrusion is necessary to the achievement of a state goal and carries with it no more harm than is required.

In the field of criminal law, a forced bodily invasion has been found permissible when it was the only way possible to preserve fast-disappearing evidence, or when it was the only means of establishing a crucial fact. *Winston v. Lee*, 470 U.S. 753 (1985). See also, *Schmerber v. California*, 384 U.S. 757 (1966) (same outcome under due process standard). The law on mandatory testing to detect the presence of drugs is evolving, but such tests have also been declared unconstitutional, under the Fourth Amendment, absent a reasonable suspicion of impairment on the job or a compelling state interest in regulating a particular industry. Compare, *Capua v. City of Plainfield*, 643 F. Supp. 1507 (D.N.J. 1986) with *Shoemaker v. Handel*, 795 F.2d 1136 (3d Cir. 1986) cert. denied 107 S. Ct. 577 (1986) and *National Treasury Employees Union v. von Raab*, \_\_\_\_ F.2d \_\_\_\_ (5th Cir. 1987) (reported at 2 IER Cases 15).

On the other hand, compulsory health policies such as vaccination or compulsory blood tests for public health reasons generally have been permitted in the past. Some of these policies are relatively easy to justify under a necessity test. For easily communicable diseases, for example, it is imperative for vaccinations to be universal. See *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (smallpox vaccinations).

A second kind of harm flowing from some proposals for compulsory testing is the requirement of being tested, or testing negative, as a precondition for receiving important rights and public benefits to which one would otherwise be entitled. Two such proposals specifically considered by the CDC at its Atlanta meeting were testing as a condition for receiving a marriage license and testing as a condition for hospital admission (discussed in detail below). Potential

denial of constitutionally-protected rights, such as marriage, undoubtedly would trigger a heightened examination of the actual efficacy of the scheme to further public health interests.

Third, compulsory testing allows the government to collect and store highly sensitive personal information about the persons tested, often including not just names and test results, but answers to questions about sexual activities, partners, and drug use.

In some situations, government collection and recording of information for health purposes has been allowed if stringent safeguards for confidentiality were maintained. *Whalen v. Roe*, 429 U.S. 589 (1977). However, when realistic threats to privacy of the records have existed, the Supreme Court has ruled that data collection must be limited to what can be demonstrated to be necessary to achieve the particular health goal in question. *American College of Obstetricians and Gynecologists v. Thronburgh*, 54 U.S.L.W. 4618 (1986) (ruling unconstitutional a Pennsylvania statute that required doctors performing abortions to report names, addresses, and other identifying information to the state health department).<sup>12</sup>

Federal courts have also demonstrated a willingness to more closely scrutinize laws which permitted government access to information believed to be especially sensitive, such as psychiatric records. See *Hawaii Psychiatric Society v. Ariyoshi*, 481 F.Supp. 1028 (D.Ha. 1979); *McKenna v. Fargo*, 451 F.Supp. 1355 (D.N.J. 1978).

Fourth, the imposition of HIV antibody testing includes not just the relatively minor act of drawing blood, but also a risk of other medical harms. The psychological impact of learning that one is seropositive has been compared to receiving a death sentence. Sequelae include severe stress and depression, including contemplation of suicide.<sup>13</sup>

Other, nonmedical harms also are linked to punitive use of HIV antibody test results. People with AIDS, or the AIDS virus, have been arbitrarily and irrationally fired from their jobs<sup>14</sup> and excluded from schools and other facilities.<sup>15</sup> They have lost health insurance coverage, have been evicted from their homes, and have been separated from their children.<sup>16</sup> The gravity of harm associated with a positive blood test result for indications of the AIDS virus imposes a duty on

government to compel testing only if, and when, all less intrusive options have been exhausted.

Thus, the information being collected is extremely sensitive; there is a very real threat of discrimination occurring if it is disclosed; and there is a possibility of psychological harm merely from being tested. For these reasons, AIDS-related testing cannot be treated as the equivalent of a routine blood test.

Last, there are equal protection principles implicated by proposals which single out certain groups for compelled testing, thus subjecting them to the harms discussed above. Assuming that none of the proposed groups falls within a category identified in law as a suspect class (i.e., race, nationality or religion), the Fourteenth Amendment nonetheless would require a showing that differential treatment rested on more than prejudice or the recitation of any rationale, no matter how implausible. See *City of Cleburne v. Cleburne Living Center*, 105 S.Ct. 3249 (1985); *U.S. Department of Agriculture v. Moreno*, 413 U.S. 528 (1973).

#### B. Balancing the Interests

The goal of stopping the further transmission of the virus believed to cause AIDS is unquestionably a compelling state interest. Therefore, the analysis of whether compulsory antibody testing is constitutional depends on whether such testing is likely to contribute substantially to the achievement of that goal and whether less coercive methods could have substantially the same effect.

In and of itself, HIV antibody testing—unlike vaccination—does nothing to prevent the spread of infection. Without a cure, or treatment, or vaccine available, the sole function of HIV antibody testing is to identify infected persons—who would not otherwise change their behavior because they do not perceive or acknowledge themselves to be at risk—so that they can then be counseled intensively not to engage in dangerous sexual, or drug use, behaviors. Whether testing is necessary, or particularly effective, to achieve this goal is unknown. Enormous behavior change has occurred within the gay male community without mandatory testing.<sup>17</sup> Early studies of the efficacy of testing for behavior change are mixed.<sup>18</sup>

The ready, obvious alternative to compulsory testing is increasing the availability of voluntary testing, together with a broad-based prevention campaign to encourage abandonment of high-risk behaviors. This option is believed by many public health experts to be a more—not less—effective means of stopping AIDS. This is largely because, in many instances, efforts to compel testing will simply drive away those who most need to be educated and counseled.

For testing schemes which include the collection and retention by the government of the names of each applicant who tested positive, again, a less intrusive policy could fulfill the state's goals. Recording only that the test occurred, without recording the name of the person tested, would work equally well to alert the individual and to permit compilation of statistical data. The more information about identified persons which the state seeks to collect—about

sexual practices, drug use, and the names of prior sexual partners or spouses—the greater the potential for abuse and the stronger the civil liberties objections.

#### Marriage License Testing

Fewer than half the states<sup>19</sup> require all applicants for a marriage license to obtain a blood test verifying the absence of sexually transmitted diseases (usually syphilis) or, if the test is positive, to obtain a certificate of treatment before a marriage license will be issued.

Since 1980 alone, 22 states have *repealed* their premarital blood test requirements.<sup>20</sup> Blood tests have been increasingly considered too costly and inefficient a mechanism for discovering small numbers of prospective spouses who were infected with STDs.

California is the only state which has enacted a law specifically addressing the issue of testing for HIV infection at the time of marriage. The California statute, passed in 1986,<sup>21</sup> treats AIDS in the same way as conditions which are genetically linked.<sup>22</sup> The law requires that each couple seeking a license be counseled about AIDS and offered the antibody test, but taking the test is not mandatory. The same procedure applies to information and testing related to the sickle cell anemia trait and Tay-Sachs disease.

Voluntary premarital testing programs, coupled with counseling and more aggressive efforts to inform marriage license applicants about HIV infection and risk-reduction behavior, pose no civil liberties problems.

The most extreme version of a proposal for mandatory testing would result in the denial of a marriage license if either person tested positive. Absolute denial of a license infringes on what has been recognized as a fundamental right—the right of two persons to marry. Denial of marriage can be justified only by a law which is narrowly tailored to serve a compelling state interest. *Zablocki v. Redhail*, 434 U.S. 374 (1978) (finding unconstitutional a Wisconsin law which denied a marriage license to any person owing past due child support for children of a previous marriage or union). Precluding HIV-infected persons from marrying is an inadequately-fashioned means to achieve the goal of AIDS prevention. It does not stop future sexual behavior; it may actually encourage less safe behavior by its foreclosure of a marriage relationship; and there are ample less coercive alternative means to achieve the same end.

A policy of requiring the test, informing the prospective spouse, counseling about risk-reduction behavior, and then issuing the marriage license, regardless of the test result, is also objectionable on civil liberties grounds, because it forces persons to take the test in order to be married and informs not only the spouse but also the government of the results.

Even when the marriage is eventually allowed to occur, a premarital test is too clumsy a mechanism for stopping either sexual or perinatal transmission of the virus. The sexual behavior of most Americans simply no longer conforms to a statutory scheme premised on the assumption of non-existent or *de minimis* premarital and

extramarital sexual activity. Most Americans begin sexual activity long before marriage. The average age at which Americans begin sexual activity today is 15.7 for males and 16.2 for females.<sup>23</sup> The median age of first marriage is 25.7 years for men and 23.1 years for women.<sup>24</sup> After marriage, sexual activity occurs with persons other than the spouse. A recent study found that 26% of husbands and 21% of wives had extramarital relationships.<sup>25</sup>

In addition, there is a major practical problem which renders premarital HIV testing infeasible. If all or most of those who test negative cannot be considered a true negative unless the test is repeated some time later, issuance of marriage licenses would have to be routinely suspended for weeks, or months, pending a second test. The impact of a mandatory HIV screening test may be to drive people away from marriage.

To some extent, premarital AIDS tests are being considered as a way to prevent transmission to children by reaching prospective parents before pregnancy. Marriage license testing would be only remotely connected to such a goal. The great majority of children with AIDS have been born to unmarried parents. In New York, where 45% of the cases of pediatric AIDS have occurred, 83% are the children of unmarried parents.<sup>26</sup>

At its best, HIV testing to decrease perinatal transmission may be compared to screening for genetic disorders which is sometimes done prior to marriage (as the California law recognizes by placing HIV tests in that category). But the history of mandatory genetic screening for certain traits teaches us a powerful lesson about the dangers of such programs. Although motivated by the desire to alert prospective parents to the risk of serious or fatal diseases in their children, these programs soon became examples of how mass screening can backfire. Best known are the attempts to screen for sickle cell anemia.<sup>27</sup>

In 1970, a single, inexpensive and relatively reliable test for sickle cell hemoglobin became available. Shortly thereafter, a number of states enacted sickle cell testing programs. Some were compulsory, and none had specific confidentiality protections. Although well intentioned, these programs, and the attention they generated, triggered panicked and

discriminatory responses. There was confusion over the difference between carrying the trait and having the disease. Some airlines grounded all black employees because of fears that a sickling crisis might occur if a plane depressurized; some insurance companies began charging higher premiums of sickle-cell carriers; and the armed forces considered deferring enlistment of all carriers.<sup>28</sup>

In reaction to this over-reaction, legislatures which had passed mandatory testing laws amended them to make the test voluntary. This process occurred in six states (Georgia, Illinois, Maryland, Massachusetts, New York and Virginia), and the District of Columbia.<sup>29</sup> Other testing programs were repealed in Kansas, Louisiana, Michigan, New Mexico, North Carolina and Ohio.<sup>30</sup> When Congress passed the National Sickle Cell Anemia Control Act, in 1972, it expressly limited federal funding to voluntary testing programs. 42 U.S.C. 300b (a)(1). Today, only six states retain sickle cell testing programs for marriage license applicants, and all but one are voluntary.<sup>31</sup> Congress repealed the federal legislation in 1981.<sup>32</sup>

In sum, marriage license bureaus are a poor point for massive HIV testing because such a program would identify so few and miss so many of those who are infected—precisely the reason why a majority of states have dispensed with premarital blood tests for STDs.

### Testing of Pregnant Women

Perinatal transmission of the AIDS virus has been documented to occur during pregnancy, during labor and delivery and, in one case, shortly after birth, presumably by breastfeeding.<sup>33</sup> The extent of the risk of transmission by an infected mother to an infant is unknown. Studies have reported transmission rates ranging from 0% to 65%.<sup>34</sup> Additional studies are now in progress to better quantify the risk of transmission, but no data from them have yet been published.

In addition to the risk of transmission to the fetus, physicians are concerned that pregnancy may increase the risk that women who are infected with the AIDS virus will develop full-blown AIDS or ARC. The immune system weakens during pregnancy, with a ratio of T-helper to T-suppressor

*"Public health officials across the country have been virtually unanimous in agreeing that control measures such as mandatory testing could drive at-risk people away from, not toward, our public health system. If HIV-infected people feared measures that could lead to additional discrimination or quarantine, they would not cooperate with the programs of counseling, education, and testing that are our best current weapons against AIDS."*

*"Furthermore, the major public health value of antibody testing is as an adjunct to a program of voluntary, confidential risk-reduction counseling to help control the spread of infection. With no effective treatment available, testing must be accompanied by counselors who are trained to help people understand the test results and how to reduce the risk of transmitting the virus to others."*

*". . . better clinical indicators of AIDS and ARC than the antibody test are available. A positive result on the HIV antibody test identifies only those people who have been infected with the HI virus. Other tests and methods that determine immunosuppression will be of more help in diagnosing AIDS or AIDS-related illness, when used in conjunction with clinical evaluation."*

— From testimony presented by Commissioner of Health, Stephen C. Joseph, MD, MPH, to the New York State Department of Insurance

cells reaching its lowest point in the third trimester. Thus, both for reasons of their own health and the health of the future child, pregnant women have strong reasons to know whether they are infected with the AIDS virus. If they are, they may want to consider abortion; if the pregnancy is continued, information about whether they are seropositive may be relevant to their attending physician.

As a comparison, amniocentesis, which tests for chromosomal abnormalities and hereditary diseases, is recommended for pregnant women over the age of 35.<sup>36</sup> No law compels pregnant women aged 35 and older to undergo that test, however, much less all pregnant women generally.

Moreover, the demographics of AIDS now are such that forcing pregnant women in high-risk groups, but not others, to be tested would impose the harms of testing disproportionately by race and sex as well. Approximately 75% of heterosexuals with AIDS, 73% of women with AIDS, and 92% of children with perinatally acquired HIV infection are black or Hispanic.<sup>37</sup>

On December 6, 1985, the CDC formally recommended that pregnant women in the following high-risk groups be offered counseling services and HIV testing: (1) those with evidence of HIV infection; (2) IV drug users; (3) current or past sexual partners of men in high-risk groups; (4) women born in countries where heterosexual transmission is thought to be frequent; and (5) prostitutes. For women not in those groups, the CDC stated that "[r]outine counseling [sic] and testing is not recommended . . . due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population."<sup>38</sup> *MMWR* 721. Mandatory testing was *not* recommended for any group of pregnant women.

Another extremely important concern relevant to mandatory or voluntary testing of pregnant women is the sensitivity required for policies involving decision-making about procreation and abortion. Counseling about pregnancy outcome cannot be conducted in such a way that its goal is less to inform than to influence which option a woman will choose. *Akron Center for Reproductive Health, Inc. v. City of Akron*, 462 U.S. 416, 444 (1983). "Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy than a woman's decision . . . whether to end her pregnancy. A woman's right to make that choice freely is fundamental." *American College of Obstetricians and Gynecologists v. Thornburgh*, 54 U.S.L.W. at 4625.

### Hospital Admissions

The standard medical practice for the use of any test as a diagnostic tool is to have the test done when there are clinical indications that justify it. This individualized approach relies on the physician's professional judgment, in each case, as to when a certain test would be useful.

Assuming that informed consent protocols are followed, there are no civil liberties problems with testing based on a physician's assessment that the results would be helpful in the clinical management of a particular case. Identification of which patients should be tested for medical reasons

appropriately resides with the attending physician's judgment. In some geographic areas, and for some types of care (e.g., obstetrics), some physicians may decide to routinely seek HIV antibody tests. Again, so long as patients are fully informed about the legal and medical ramifications of such tests and have the opportunity to decline them, there is no civil liberties problem.

Even if data emerge in the future indicating higher seroprevalence rates among pregnant women than were thought to be the case in December, 1985,<sup>39</sup> it would be difficult to justify a state law which required mandatory HIV testing for every pregnant women in the United States.

Preventing medical conditions which threaten the health of the woman or the fetus, and which can be detected during pregnancy, is clearly an important state goal. Other health-threatening but detectable conditions, however, are not the subject of forced tests. Reliance, as current CDC recommendations provide, on offering counseling and testing is the preferred method for achieving this goal.

Even with voluntary testing, however, there is an important civil liberties concern as to the adequacy of confidentiality protections for medical records. The danger of unauthorized disclosures of the highly sensitive, personal information contained in medical records is all the more severe when there exists a substantial risk of discrimination. New statutes and institutional policies are needed to adequately safeguard this information.

The justification for imposing mass testing on all persons admitted to hospitals is weak. Approximately 37 million persons pass through American hospitals each year. About 30% of them are aged 65, or over, and 22% are aged 45 to 64.<sup>40</sup> Very few of these persons, who together account for more than half of all hospital patients, are likely to be at high risk of HIV infection. Among other patients, one could expect that the infection level will be about the same as that for the general population, which is quite low. Administering HIV tests to all hospital admissions, regardless of clinical indications, would cost hundreds of millions of dollars for little return.<sup>41</sup>

Another possible reason for universal testing of hospital admissions—prevention of viral transmission within the hospital setting—has been repeatedly ruled out as a justification by the CDC. The current CDC recommendations on preventing transmission of HIV infection from hospital patients to others state: "Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended. . . . Results of such testing are unlikely to further reduce the risk of transmission which, even with documented needlesticks, is already extremely low." *MMWR* 681 (Nov. 15, 1985). This recommendation was reaffirmed in April, 1986, as to surgical procedures: "Routine serologic testing for evidence of HTLV-III/LAV infection is not necessary for . . . patients undergoing invasive procedures, since the risk of transmission in this setting is so low." *MMWR* 221 (April 11, 1986).

In addition to these reasons against mandatory testing, the practical reality is that many invasive procedures are

performed in emergency situations, when waiting to learn of HIV antibody results is not possible. During emergency procedures, hospital staffs necessarily must act as though any patient could be infected. That same guideline is the principle recommended by CDC for all care situations.

### **Patients at Family Planning, STD, and Drug Abuse Treatment Clinics**

Each year, millions of Americans voluntarily seek services at thousands of government-funded, family planning, STD, and drug abuse treatment clinics. The CDC proposes a requirement which would force every one of these persons to take a test for the AIDS virus in order to receive the services offered by these programs. Tragically, the chief result of such a requirement would likely be to drive away millions of persons who are at risk for HIV infection, thus losing the opportunity to educate and counsel them.

HIV antibody testing, in these programs, is currently voluntary. Indeed, in at least some settings, such as family planning clinics, far too little is being provided related to AIDS prevention—including counseling and access to the test. But there is no indication that requiring the test would do anything except deter people from attending the clinics.

According to a recent publication, approximately half of all women who sought family planning care had been tested for STDs.<sup>40</sup> Current guidelines of the Planned Parenthood Federation of America for STD screening in their affiliate clinics base recommendations for which groups of patients should be tested on positivity rates in the local community and on each woman's medical and sexual history.<sup>41</sup> Assuming that informed consent procedures are followed, and counseling provided, protocols could be developed for recommending that certain patients consider HIV antibody testing. In any case, more AIDS-related education should be done.

### **The Need for New Laws**

There is a crisis building in the formulation of AIDS-related public health policy, but it is not the tension, so often depicted, between public health and civil liberties—it is the conflict between public health and the absence of protection for civil rights and liberties. As the number of AIDS cases multiplies, so will the number of AIDS-related discrimination cases. Many discrimination cases result from breaches of confidentiality in the medical care setting: for example, when insurers learn about HIV testing from receiving the bill for it; or when employers are told by doctors of positive test results.

It is incumbent on public health officials, for public health reasons, to demand that Congress and state legislatures pass laws that will make possible an effective response to the AIDS crisis. Americans must be willing to seek counseling, perhaps including the test; to seek treatment if they show signs of illness; and to acknowledge the need to refrain from behaviors which could place themselves and others at risk. So long as any association with AIDS can lead to loss of job, of insurance, of housing, and of benefits, that cooperation and thus an effective response to AIDS will be impossible.

There are four components to the necessary legal framework on HIV antibody testing.

1. To the greatest extent possible, testing must be offered on an anonymous basis. Anonymous testing is the single best protection against discrimination, and its wide availability will do more than any other single policy to encourage people to participate in testing programs.
2. Much stronger laws protecting the confidentiality of medical records must be enacted. When anonymity is not possible (as in hospitals, e.g.), records of AIDS-related care must be insulated from casual or deliberate disclosure to anyone not having a legitimate reason to know.
3. By one means or another, we must provide for continuous access to health insurance. Whether HIV antibody testing by insurance companies is forbidden, or Medicare is amended to cover AIDS-related illness, or special health insurance is offered by the government, we cannot allow loss of access to health care to be the price of obtaining an HIV antibody test.
4. Congress must pass laws to prohibit discrimination based on AIDS, or AIDS-related, testing in employment, housing, and public accommodations. Federal law now prohibits job discrimination, based on handicap, only for federal workers and employees of companies with federal contracts. State laws are spotty. We must have comprehensive legislation.

These measures are imperative as much for public health reasons as for civil liberties reasons.

### **A Prevention and Education Program**

The most effective response to AIDS, short of developing a cure and a vaccine, is education and prevention. With approximately two million Americans already thought to be carrying the virus, it is not rational to try to identify relatively few infected persons, by selected testing programs

#### **SIECUS POSITION STATEMENT ON AIDS**

**AIDS (Acquired Immune Deficiency Syndrome)** is a major public health concern with the potential to affect all segments of our population. SIECUS calls upon our society to give this crisis sufficient attention and to provide funds and strategies to combat this pandemic. Therefore, SIECUS strongly urges the following:

1. Immediate and increased government and private support for research on prevention and treatment.
2. Provision of adequate medical, financial, and social service resources for persons with AIDS and their loved ones.
3. Educational programs to enlighten the public about the scientific facts as they become available in order to allay unwarranted fears.
4. Education about the transmission of AIDS and how to prevent such transmission.
5. Reaffirmation of our society's commitment to the civil rights of persons diagnosed with AIDS or thought to have the IAV/HTLV-III virus.

This position statement was adopted by the SIECUS Board of Directors in 1985.

for counseling. It is urgent that we adopt education and counseling programs that reach everyone.

AIDS is an issue on which we desperately need farsighted and innovative leadership in developing programs that will truly work. We need to insure that information on how to avoid sexual practices and drug use practices that spread the disease reaches every American. We need to make condoms easily and conveniently available to all sexually active persons, including teenagers. And we should, if necessary, supply clean, disposable hypodermics to stop the transmission caused by sharing of needles.<sup>42</sup> Private, voluntary testing—anonymous if possible but with confidentiality assured—should also be widely available.

### Confidentiality

*"Because of the stigma that has been associated with AIDS, many afflicted with the disease or who are infected with the AIDS virus are reluctant to be identified with AIDS. Because there is no vaccine to prevent AIDS and no cure, many feel there is nothing to be gained by revealing sexual contacts that might also be infected with the AIDS virus. When a community or a state requires reporting of those infected with the AIDS virus to public health authorities in order to trace sexual and intravenous drug contacts—as is the practice with other sexually transmitted diseases—those infected with the AIDS virus go underground out of the mainstream of health care and education. For this reason current public health practice is to protect the privacy of the individual infected with the AIDS virus and to maintain the strictest confidentiality concerning his/her health records."*

—from Surgeon General C. Everett Koop's Report on AIDS

We should not be deterred from educational programs by the incorrect perception that most Americans are offended by accurate, nonjudgmental information about human sexual behavior. A 1985 Harris poll found that 85% of those surveyed thought sex education should be taught in the schools. The need for this information is urgent. As Surgeon-General Everett Koop said in October, 1986: "Many people, especially our youth, are not receiving information that is vital to their future health and well-being because of our reticence in dealing with the subjects of sex, sexual practices and homosexuality. This silence must end." We agree with this statement and urge that aggressive AIDS prevention campaigns be made a top priority of the federal and state governments.

1. Cladd E. Stevens, M.D., letter of Jan. 30, 1987.
2. Ward, et al., "Laboratory and epidemiologic evaluation of an enzyme immunoassay for antibodies to HTLV-III," 256 J. Am. Med. Assn. 357 (1986).
3. The Western blot became the first confirmatory test to be licensed by the Food and Drug Administration shortly after the CDC conference on testing. "Biotech Research, DuPont AIDS Test Cleared by FDA," Wall Street Journal, May 1, 1987 at 5.

4. CDC, "Transfusion-associated human T-lymphotropic virus type III/lymphadenopathy-associated virus infection from a seronegative donor—Colorado," 35 MMWR 389 (1986); Salahuddin, et al., "HTLV-III in symptom-free seronegative persons," 2 Lancet 1418 (1984). See also, Marlink, et al., "Low Sensitivity of ELISA Testing in Early HIV Infection," 315 New Engl. J. Med. 1549 (1986).
5. Barry, Cleary and Fineberg, "Screening for HIV Infection: Risks, Benefits and the Burden of Proof," 14 Law Medicine and Health Care 259, 263 (Dec. 1986). As points of comparison for level of infection, the military reports a seroprevalence level among recruits of 0.15 per cent, and alternate test sites report a seroprevalence level of 17.3 per cent. See 35 MMWR 284 (1986) and 35 MMWR 421 (1986).
6. Davis, "Serologic Tests for the Presence of Antibody to Human T-Lymphotropic Virus Type III" (1986), Table 3 at 17.
7. Barry, Cleary and Fineberg, *supra* note 5.
8. Davis, *supra* note 6.
9. Burke, et al., 256 J. Am. Med. Assn. 347 (1986).
10. The framework described derives from parallel constitutional standards found in a number of different fields of law. See, e.g., Akron Center for Reproductive Health, Inc. v. City of Akron, 462 U.S. 416 (1983) (decision-making autonomy as part of a right of privacy); Zablocki v. Redhail, 434 U.S. 374 (1978) (infringements on the right to marry); Winston v. Lee, 470 U.S. 753 (1985) (prosecution's attempt to secure evidence by forced surgery); Shapiro v. Thompson, 394 U.S. 618 (1969) (residency requirements for welfare benefits as infringements on the right to travel); and Police Department of Chicago v. Mosley, 408 U.S. 92 (1972) (penalties against certain expressions protected by the First Amendment).
11. See Nassau County School Board v. Arline, 55 U.S.L.W. 4547 (March 3, 1987) (standards of Rehabilitation Act of 1973, 29 U.S.C. & 709 et seq., apply to acts of discrimination based on handicaps which are communicable diseases).
12. In *Thornburgh*, the Supreme Court examined the degree of detail required in the abortion reports (age, race, county of resident, marital status, length of pregnancy, method of payment) and the fact that the details, although not the names, were public records, against a background of what plaintiffs described as "a continuous pattern of violence and harassment directed against the patients and staff of abortion clinics." 54 U.S.L.W. at 4623. The Court concluded that the Pennsylvania regulations "raise the spectre of public exposure and harassment" of women who chose to have abortions. *Id.* The Court likened the case to earlier decisions in which it had invalidated laws requiring self-identification to the government by persons who held unpopular political beliefs. *Lamont v. Postmaster General*, 381 U.S. 301 (1965) (Post Office requirement that addressees specifically request delivery of "communist" materials in order to receive them); *Talley v. California*, 362 U.S. 60 (1960) (local ordinance against unsigned handbills), and *NACP v. Alabama ex rel. Patterson*, 357 U.S. 449 (1958) (state law requiring disclosure of NAACP membership list).
13. Coates, Morin and McKusick, "Consequences of AIDS Antibody Testing Among Gay Men," unpublished ms., Jan. 21, 1986; Martin, "Causes and Consequences of Testing for HTLV-III Antibody: The Gay Community Experience," in N.I.H., "Impact of Routine HTLV-III Antibody Testing of Blood and Plasmas Donors on Public Health" (1986); Pinsky, "Psychosocial Impact of Anti-HTLV-III Notification: The New York Experience," in N.I.H., *supra*.
14. See, e.g., *Shuttleworth v. Broward County, AIDS Policy & Law* (Dec. 17, 1986) at 1; *Cronan v. New England Telephone Co.*, BNA Daily Labor Report (Sept. 16, 1987); *Doe v. Charlotte Memorial Hospital, AIDS Policy & Law* (Aug. 13, 1986) at 1; *Department of Fair Employment and Housing v. Raytheon*, BNA Daily Labor Report (Feb. 13, 1987).
15. See, e.g., *In re District 27 Community School Board v. Board of Education of City of New York*, 130 Misc. 2d 398 (N.Y. Sup. Ct. 1986); *Thomas v. Atascadero School District*, \_\_\_\_ F.Supp. \_\_\_\_ (S.D. Cal. 1986); *Bogart v. White*, No. 86-1444 (Clinton Cty. Ind. Circuit Ct., Apr. 10, 1986).
16. See, e.g., *In re Doe v. Doe, AIDS Policy & Law* (June 4, 1986) at 10; *Stewart v. Stewart, AIDS Policy & Law* (Dec. 3, 1986) at 3; and *NGRA v. Great Republic Insurance Co., AIDS Policy & Law* (May 21, 1986) at 4. See generally, New York City Commission on Human Rights, *Report on Discrimination Against People with AIDS—November 1983 to April 1986*.
17. CDC, "Self-Reported Behavioral Change Among Gay and Bisexual Men—San Francisco," 34 MMWR 613 (1985).
18. See Coates, Morin and McKusick, *supra* note 9; Fox, Odaka and Polk, "Effect of learning HTLV-III/LAV antibody status on subsequent sexual activity," presented at the International Conference on AIDS, Paris, France, June 24, 1986; and Martin, "Sexual behavior patterns, behavior change, and occurrence of antibody to LAV/HTLV-III among New York City gay men," presented at the International Conference on AIDS, Paris, France, June 24, 1986.

19. Blood tests are required by 20 states plus the District of Columbia and Puerto Rico. *Alabama*: Ala. Code Sec. 22-16-5; *California*: Cal. Civ. Code Sec. 4300 to 4309 (West 1983); *Connecticut*: Conn. Gen. Stat. Sec. 46b-26 (1986); *Florida*: Fla. Stat. Ann. Sec. 741.051 (West 1986); *Georgia*: Ga. Code. Ann. Sec. 19-3-40 (1986 Cum Supp.); *Illinois*: Ill. Ann. Stat. ch. 40, §204 (1986 Supp.); *Indiana*: Ind. Code Ann. Sec. 31-7-4-1 (West's 1986); *Louisiana*: La. Rev. Stat. Ann. 9.241. (1965); *Massachusetts*: Mass. Gen. L. ch. 207, Sec. 28A (1981); *Michigan*: Mich. Stat. Ann. Sec. 14.15(5241); *Mississippi*: Miss. Code Ann. Sec. 93-1-5(e) (1986); *New Jersey*: N.J. Stat. Ann. Sec. 37-1-20 to 37-1-24; *New Mexico*: N.M. Stat. Ann. Sec. 40-1-11 and 24-1-7 to 24-1-8; *North Carolina*: N.C. Gen. Stat. Sec. 51-9 (1984); *Oklahoma*: Okla. Stat. Ann. tit. 45, Sec. 31; *Pennsylvania*: Pa. Stat. Ann. tit. 48, Sec. 6-6; *Puerto Rico*: LRRA tit. 31, Sec. 236 to 240. Supp. Attached. *Rhode Island*: R.I. Gen. Laws Sec. 15-2-3; *Utah*: Utah Code Ann. Sec. 30-1-2; *Washington*: Wash. Rev. Code Sec. 26.04.165 and 26.04.210; *Washington, D.C.*: D.C. Code Ann. Sec. 30-117 (1981); *West Virginia*: W. Va. Code Sec. 48-1-6a (1986).
20. 1980—Missouri (L. 1980, p. 441, S.B. No. 532);  
1981—Kansas (L. 1981, ch. 16, §81)  
Ohio (139 v. H694)  
Wisconsin (L. 1981, c. 20, Sec. 1777r, s)  
1982—Delaware (63, Del. Laws, c. 457, Sec. 1)  
Iowa (Acts 1982, 69 G.A., ch. 1152, Sec. 3)  
Kentucky (1982, c. 146, Sec. 4)  
1983—Arkansas (Acts 1983, No. 378, Sec. 2)  
Hawaii (L. 1983, c. 259, Sec. 1)  
Montana (Sec. 3, ch. 154, L. 1983)  
Nebraska (L. 1983, L.B. 497, Sec. 1)  
North Dakota (S.L. 1983, ch. 175, Sec. 3)  
Texas (Act 1983, 68th Leg., p. 2899, ch. 493, Sec. 2)  
1984—Alaska (Sec. 4, ch. 134, SLA 1984)  
Arizona (L. 1984, ch. 30, Sec. 1)  
Virginia (Acts 1984, c. 140)  
1985—Maine (L. 1985, c. 8)  
New York (1985 Sess. Laws, ch. 674, p. 1713)  
Tennessee (Acts 1985, ch. 13, Sec. 1)  
Wyoming (L. 1985, ch. 22, Sec. 2)  
1986—New Hampshire (1986; 198:23, XLVII to XLIX)  
Vermont (Public Acts 1986 Sess., eff. April 9, 1986)
21. 1986 stat., ch. 1460, S.B. 1478.  
22. Although not a genetic condition, AIDS is transmitted sexually and perinatally. Thus, information about the antibody status of each partner is highly relevant to the couple's decision-making about whether to have children, comparable to the way that knowledge about whether each is a carrier of certain recessive genes is important.  
23. Zelnick and Shah, "First Intercourse Among Young Americans," 15 Fam. Plan. Perspec. 64 (March/April 1983).  
24. "The Way We Live," New York Times, Dec. 14, 1986 at p. E-9 (reporting 1986 Census Bureau data).
20. *Id.*  
25. Blumstein and P. Schwartz, *American Couples* (1983) at 273.  
26. 34 MMWR 721 (1985) and New York City Department of Health, AIDS Surveillance Office, February, 1987.  
27. Sickle cell anemia is a serious genetic blood disorder which causes severe physical debilitation and often results in death at an early age. Because it primarily affects black persons, programs designed to detect the trait for sickle cell overwhelmingly affected a racial minority already subject to widespread discrimination.  
28. P. Reilly, *Genetics, Law and Social Policy* (1977) at 74.  
29. "Sickle Cell Legislation: Beneficence or 'The New Ghetto Hustle?'" 13 J. Fam. L. 278, 279 n.6 (1973-4).  
30. *Id.*  
31. Tests for sickle cell anemia trait are allowed in California, Georgia, Illinois, Indiana, Kentucky and New York. *The Book of States*, (1982) at 80-81. In Kentucky, it is mandatory. For a critique of this legislation, see "Sickle Cell Legislation," *supra* note 22.  
32. Pub. L. 97-35, Title XXI, §2193 (b) (l), Aug. 13, 1981, 95 Stat. 827.  
33. CDC, "Recommendations for Assisting in the Prevention of Perinatal Transmission of HTLV-III and LAV and AIDS," 34 MMWR 721 (1985).  
34. *Id.*  
35. Among female military recruits in 1985-6, for example, the seroprevalence rate was 0.6 per 1,000. 35 MMWR 421 (1986).  
36. U.S. Department of Health, Education and Welfare, Task Force Report: Predictors of Hereditary Disease or Congenital Defects, Consensus Development Conference on Antenatal Diagnosis 35-47 (1979).  
37. CDC, "AIDS Among Blacks and Hispanics—United States," 35 MMWR 655, 666 (Oct. 24, 1986).  
38. National Center for Health Statistics, *Utilization of Short Stay Hospitals, 1984 Annual Summary* (1986), Table 1 at 21.  
39. If each person tested were billed an average of \$20, the total cost to insurers, individuals, Medicaid and Medicare would be \$740 million a year. By comparison, the total requested for all prevention efforts in President Reagan's FY 1988 budget is \$121 million.  
40. Aral, et al., "Screening for Sexually Transmitted Diseases by Family Planning Providers: Is it Adequate and Appropriate?" 18 Fam. Plan. Persp. 225 (November/December 1986).  
41. *Id.*  
42. See Committee on Medicine and Law, "Legalization of Non-Prescription Sale of Hypodermic Needles: A Response to the AIDS Crisis," 41 Record of the Assn. of the Bar of the City of New York 809 (November 1986) (endorsing the repeal of laws prohibiting the purchase of hypodermic needles without a prescription).

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*Nan Hunter is staff counsel and coordinator of the national ACLU's Work Against AIDS-Related Discrimination.*

## ACLU PUBLICATIONS

### AIDS: BASIC DOCUMENTS

Medical and Legal documents relevant to the most common policy issues concerning AIDS. Excellent introduction or briefing book for attorneys, policy makers, and journalists.  
100 pp., \$5.

### NATIONAL DOCKET: AIDS CASES AND SEXUALITY AND THE LAW CASES

Combined docket of all known cases in active litigation, in federal or state courts, which involve AIDS, lesbian and gay rights, or other discrimination based on sexuality.  
125 pp., \$10.

### AIDS: AIDS AND CIVIL LIBERTIES

Leaflet in question and answer form, outlining the ACLU's response to most frequently asked questions about AIDS. For use in classroom and for general educational purposes.  
Single copy free.

### MODEL LAWS (single copies free):

Model statute dealing with AIDS testing and confidentiality concerns, such as: informed consent, confidentiality of medical records, access to anonymous testing, and impermissible uses of HIV antibody tests and of possible future antigen tests.

Model law prohibiting discrimination based on AIDS. Text of law adopted by Austin, Texas and Los Angeles.

All orders must be prepaid and, except for free publications, must include \$1 for the first copy, and \$.50 for additional copies, for postage and handling. Make check or money order payable to American Civil Liberties Union and send to: Literature Department, ACLU, 132 West 43rd Street, New York, NY 10036.

# Pre- and Post-test Counseling for Individuals Taking the HIV Antibody Test

Michael Shernoff, CSW, ACSW

Last year, Roger, a friend and a colleague, began to think seriously about taking the HIV antibody test. A gay health care professional, who has been providing services to persons with AIDS since 1982, he is more than usually knowledgeable about AIDS. A regular reader of such publications as *The New England Journal of Medicine* and *The Lancet*, Rodger was prompted to consider the test when he learned that his ex-lover had tested negative.

After exploring in therapy, over the course of a year, possible reactions to both negative and positive test results, Rodger had his physician draw blood for the test. A month later, Rodger's physician personally informed him that his test results indicated exposure to HIV and spent the next half hour reassuring him that, as far as could be determined, he was completely healthy and asymptomatic for either AIDS or ARC (AIDS-Related Complex).

Thus began six months of the most severe depression Roger had ever experienced. Although completely asymptomatic, with perfectly normal blood chemistry, Rodger became obsessed with "when he got AIDS," instead of if he had AIDS. He reported being tormented by chronic intrusive thoughts about his own death, experiencing terrifying nightmares about AIDS and dying, and he would suddenly, and for no apparent reason, break into tears.

Just prior to beginning antidepressant medication, his symptoms of depression began to abate, and although he is completely healthy, to this day having a simple headache still provokes the thought that he might have toxoplasmosis or the cytomegial virus in his brain. Rodger's experience vividly illustrates how a positive test result can be psychologically devastating to a well-functioning and knowledgeable individual, even when he or she has had the benefit of pre- and post-test counseling.

Not too long ago, a colleague, engaged in AIDS education work with I.V. drug users in Brooklyn, encountered a man who had been paid \$15 by an unscrupulous researcher to be tested. He had no counseling, whatsoever, even after he was informed of his positive antibody status. In the aftermath, the man abandoned his wife and child out of fear that he might give them AIDS and relapsed into active heroin

addiction. By the time my colleague had contact with him, in a "shooting gallery," he was in a deep paranoid and psychotic state.

One of my own patients, Kenneth—a young man preoccupied with sexual guilt—has been tested four different times, each with a negative result. In fact, long before his first test he had done nothing that might have exposed him to the AIDS virus. Nonetheless, he still refuses to believe that his test results are accurate, despite extensive counseling prior to, and following, each test.

Pre- and post-test counseling is critical for several reasons. At a minimum, a person should be told exactly what test results mean and whether or not he or she has been exposed to the virus. Also, counseling should provide a setting where all questions can be asked, and answered. Ideally, the counselor should encourage a patient to express and explore all his or her feelings regarding possible test results.

## Pre-test Counseling

A number of key issues should be raised in pre-test counseling. A person should explore exactly why he or she has decided to be tested and what he or she expects to learn. Many people, for example, seek the test in order to discover whether or not they will get AIDS. When informed that the test does not predict whether one will get AIDS, some choose not to take it.

For those who, nevertheless, take the test, pre-test counseling must help prepare them for the results by beginning to explore their feelings about what the results might mean, and for the fact that the waiting period will be, most likely, one of heightened anxiety. Also, if a counselor judges that the person wishing to take the test is mentally unstable, it is usually in that person's best interest to discourage him or her, in strong terms, from taking the test.

Experience from all parts of the country confirms that a positive test result, at a minimum, increases feelings of guilt, anxiety, and depression. At times, such reaction can be severe. Despite good pre- and post-test counseling, one of my patients, with a positive result, suffered a psychiatric decompensation requiring medication and hospitalization.

## **Post-test Counseling**

Post-test counseling has an additional public health role to play. Each person, who tests positive (who is seropositive), needs specific information on how to prevent the spread of the virus, and on how to avoid any additional exposure; and each person, who tests negative, needs similar information on how to remain uninfected. In both cases, specific and explicit counseling about safer sex is required.

The initial reaction to a positive test result is most often profound shock—even when a person has prepared him- or herself by assuming that he or she is seropositive. It is common for a person to think: "Oh God, I am going to die... and relatively soon!" At this point, in a post-counseling session, most people appear to shut down emotionally and not to hear much else that a counselor has to say. Consequently, only a fraction of the imparted information filters through to a person who has just learned of his or her positive antibody status. Because of this phenomena, more than one post-test counseling session should be required for individuals who test positive; otherwise, it is not likely that they will be able to appreciate the complexities of what it means to be seropositive, but asymptomatic. Indeed, it is virtually impossible to begin immediately to integrate such new information: living in a seropositive "gray zone" raises a variety of issues and feelings that require time to be integrated.

There are, for example, a variety of possible cofactors which should be considered that may influence whether a seropositive individual develops AIDS or ARC: such as reduction or elimination of alcohol or drugs; alleviation of stress; improvement of nutrition; and, in general, taking better care of oneself. People, in their 20s, tend to take their bodies for granted and may not be aware that alcohol and other recreational drugs act as immunosuppressants. Such information can, indeed, be lifesaving and may not be heard if there is but a single post-test session—or none at all.

Counseling an individual who is HIV seropositive, as a result of being a transfusion recipient, poses special issues. First of all, notification of seropositivity almost always comes as a surprise. It is this element of total surprise that differentiates the counseling given to these seropositive individuals from that given to other seropositives who, by virtue of their membership in the high AIDS incidence groups, have often considered the possibility of their being infected. Initial reactions to notification of positive test results are often dominated by anger, as individuals feel that they have been betrayed by the medical establishment, their doctors, and fate. Helping professionals must validate—as normal responses—the accompanying anxiety, anger, and depression which may occur among these individuals. Validating these feelings is critical to the process that all seropositive individuals must go through in making successful adjustments to their new circumstances.<sup>1</sup>

Post-test counseling for seropositive individuals also needs to include the spouse/lover, since knowledge of a positive result can have a profound impact on a relationship. The need to provide supportive counseling for spouses, lovers, and family members too is important, as they are often unable to talk to those who form their usual support system because of their fear of rejection or stigmatization.

It is difficult, even for health care or psychotherapy professionals, to appreciate how great an impact a positive result has on most individuals. Quality pre- and post-test counseling is the only sensible and humane prescription for good community mental health. It should be mandatory.

1. Deitch, Denice, "Counseling the HIV Seropositive Transfusion Recipients," *Focus: A Guide to AIDS Research*, the AIDS Health Project, University of California, San Francisco, July, 1987.

*Michael Sheroff is co-director of Chelsea Psychotherapy Associates of Manhattan; member of the AIDS Task Force, New York City Chapter, National Association of Social Workers; and adjunct faculty for the Department of Education, Gay Men's Health Crisis, "the world's oldest and largest AIDS service provider organization."*

## **Relevant Publications from GMHC (Gay Men's Health Crisis)**

**WHEN A FRIEND HAS AIDS...** (1984). Michael Sheroff, with others at Chelsea Psychotherapy Associates, has written this unique and sensitive pamphlet of thoughts and suggestions to help when friends become ill. Although the suggestions and thoughts "have been adapted to the specialized needs of gay men with AIDS... they are relevant to all who are seriously ill..."

**I CAN'T COPE WITH MY FEAR OF AIDS** (1986), is a clear, informative and, again, sensitively written pamphlet for the "worried well"—men and women who are physically well—yet troubled that they may have AIDS; that they might be infected with the AIDS virus; or, as carriers, might be passing the virus on to sexual partners, spouses, or unborn children. "AIDS organizations, physicians, and therapists around the country report that thousands of people are experiencing AIDS fear." The pamphlet describes these "worried well"; talks about AIDS fear; lists its 13 symptoms; explains what can be done about it; tells how to enjoy one's life despite AIDS; and what to do if the suggestions offered have not helped.

*To obtain copies of the above, contact Jim Holmes, Gay Men's Health Crisis, Box 274, 132 West 24th Street, New York, NY 10011, (212) 807-7517. Price for each, \$20 + 15% p/h.*

## AIDS-RELATED ORGANIZATIONS

These national organizations, and organizations which have been particularly active with AIDS-related issues, can be useful in locating local programs, materials, and general or specific information on AIDS.

### AIDS Action Council

729 8th Street SE, Suite 200  
Washington, DC 20003  
(202) 547-3101

### The AIDS Institute

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

### American Foundation for AIDS

Research (amFAR)  
40 West 57th Street, Suite 406  
New York, NY 10019  
(212) 333-3118

### AIDS Public Education Program

American Red Cross  
1730 D Street NW  
Washington, DC 20003  
(202) 737-8300

### AIDS Task Force

Centers for Disease Control  
1600 Clifton Road NE  
Atlanta, GA 30333  
(404) 329-2891

### AIDS-Related Discrimination Unit

Civil Liberties Union  
123 West 43rd Street  
New York, NY 10036  
(212) 944-9800

### Gay Men's Health Crisis

Box 274  
132 West 24th Street  
New York, NY 10011  
(212) 807-6655

### Lambda Legal Defense and Education Fund

132 West 43rd Street  
New York, NY 10036  
(212) 944-9488

### Mothers of AIDS Patients (MAP)

c/o Barbara Peabody  
3403 E Street  
San Diego, CA 92102  
(619) 234-3432

### National AIDS Network

729 8th Street SE  
Washington, DC 20003  
(202) 546-2424

### National Coalition of Gay STD Services

P.O. Box 239  
Milwaukee, WI 53201  
(414) 277-7671

### National Hemophilia Foundation

110 Greene Street, Room 406  
New York, NY 10012  
(212) 219-8180

### National Lesbian and Gay Health Foundation

P.O. Box 65472  
Washington, DC 20035  
(202) 797-3708

### National Association of People with AIDS

P.O. Box 65472  
Washington, D.C. 20035  
(202) 483-7979

### San Francisco AIDS Foundation

333 Valencia Street, 4th Floor  
San Francisco, CA 94103  
(415) 864-4376

### Sex Information and Education Council of the U.S. (SIECUS)

32 Washington Place  
New York, NY 10003  
(212) 673-3850

### AIDS Information Exchange

U.S. Conference of Mayors  
1620 Eye Street NW  
Washington, DC 20006  
(202) 293-7330

### AIDS Information

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

## AIDS HOTLINES

### NATIONAL

AIDS CRISISLINE, National Gay and Lesbian Task Force, provides referral to nearest AIDS service organization anywhere in the U.S.; for reporting of AIDS-related discrimination, toll-free out of New York State: 1-800-221-7044

FEDERAL CENTERS FOR DISEASE CONTROL/  
AMERICAN SOCIAL HEALTH ASSOCIATION NATIONAL AIDS HOTLINE: 1-800-342-AIDS (24 hours)

STD NATIONAL HOTLINE: 1-800-227-8922  
AZT AND RELATED DRUGS: 1-800-843-9388

PROJECT INFORM, latest experimental drug information:  
1-800-822-7422 (California: 1-800-334-7422)

NATIONAL INSTITUTE ON DRUG ABUSE, drug treatment information: 1-800-662-HELP

NATIONAL CHILD ABUSE HOTLINE, trained psychologists deal with all sexual assaults, some AIDS-related: 1-800-422-4553 (24 hours)

AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY THERAPY, families of people with AIDS: (202) 429-1825

PAN AMERICAN HEALTH ORGANIZATION (W.H.O. U.S. Chapter), for travel to other countries information: (202) 861-3200

## STATE

Alabama: 205-261-5131\*

Alaska: 907-561-4406\*

Arizona: 602-255-1203\*

Arkansas: 1-800-482-8886, 501-661-2395\*

California, State Department of Health: 916-445-0553  
Northern: 1-800-367-AIDS  
San Francisco AIDS Foundation: 415-863-AIDS  
Southern: 1-800-922-AIDS  
Los Angeles: 213-871-AIDS  
Sacramento, AIDS & KS Foundation: 916-448-AIDS  
STD Hotline: 1-800-982-5883, 1-800-227-8922  
State Department of Health: 916-445-0553

Colorado: 303-331-8320\*

Connecticut: 203-549-6789\*

Delaware: 1-800-342-4012, 302-995-8422\*

District of Columbia: 202-332-AIDS\*  
Whitman Walker Clinic: 202-833-3234

Florida: 1-800-352-AIDS, 904-488-2905\*, 1-800-356-2437  
Miami: 305-358-HELP

Georgia (Atlanta), National Public Health Service  
AIDS Hotline: 404-329-1296, 800-342-2437\*  
AIDS Atlanta: 404-872-0600

Hawaii: 808-735-5303\*

Idaho: 208-334-5944\*

Illinois: 1-800-252-8635, 312-871-5696\*, AIDS Action Project, 312-871-5777

Indiana: 317-633-8406\*

Iowa: 515-281-5424\*

Kansas: 913-862-9360\*

Kentucky: 502-564-4478\*

Louisiana: 504-342-6711\*

Maine: 207-289-3747\*

Maryland: Health Education Resource Organization, metro Baltimore: 301-945-AIDS\*

Massachusetts (Boston): 617-536-7733, 617-727-0368\*  
Mayors Task Force on AIDS: 617-424-5916

Michigan: 517-335-8371\*

Minnesota AIDS Project: 1-800-752-4281, 612-377-6900, 612-623-5414\*  
Twin Cities: 612-870-0700

Mississippi: 601-354-6660\*

Missouri: 816-353-9902\*

Montana: 406-444-4740\*

*Note: \*State Departments of Health*  
(We would like to make this listing as accurate as possible, so please feel free to send us corrections or additional listings for your area of the United States.)

Nebraska: 402-471-2937\*

Nevada: 702-885-4988 or 5948\*

New Hampshire: 1-800-852-3345, 603-271-4487\*

New Jersey: 1-800-624-2377, 609-588-3520\*

New Mexico: 505-984-0911\*

New York: 1-800-462-1884, 518-473-0641\*  
New York City:  
Beth Israel AIDS Information Hotline: 212-420-4141  
Children and Youth AIDS Hotline, Albert Einstein College of Medicine: 212-430-3333  
Department of Health AIDS Hotline (M-F, 9am-9pm): 718-485-8111  
Gay Men's Health Crisis (24 hours): 212-807-6655  
Haitian Coalition on AIDS: 718-855-0972 or 0973  
Human Resources Administration Hotline (public assistance, food stamps, home care): 212-420-4141  
IV Substance Abuse AIDS Information, Beth Israel Medical Center: 212-420-4141  
Minority Task Force on AIDS: 212-749-1214  
National Hemophilia Foundation: 212-682-5510  
National Gay and Lesbian Task Force Crisisline, operated by the Fund for Human Dignity: 212-529-1604  
Samaritans Hotline (nonreligious 24-hour suicide prevention): 212-673-3000

North Carolina: 919-733-3419\*

Ohio: 1-800-332-AIDS, 614-466-4643\*

Oklahoma: 405-271-4061\*

Oregon: 503-229-5792\*

Pennsylvania: 1-800-692-7234, 717-787-3350\*  
Philadelphia AIDS Task Force Hotline: 215-232-8055  
Philadelphia AIDS Hotline: 215-232-AIDS

Rhode Island: 401-277-2362\*

South Carolina: 803-734-5482\*

South Dakota: 605-773-3364\*

Tennessee: 615-741-7247\*

Texas: 1-800-392-2040, 512-458-7504\*  
Dallas AIDS Project: 214-528-2181

Utah: 801-538-6191\*

Vermont: 802-863-7240\*

Virginia: 804-786-6267\*

Washington (Seattle): 206-587-4999, 206-361-2914\*

West Virginia: 304-348-5358\*

Wisconsin: 608-267-3583\*, State Medical Society: 1-800-362-9080

Wyoming: 307-777-7953\*

# The New York City Approach to AIDS

*The following are excerpts from a speech presented by New York City Commissioner of Health, Stephen C. Joseph, MD, MPH, to the Association for a Better New York, Community Council of Greater New York on April 21, 1987. Although we would like to have included the entire speech—as it is very informative and includes a number of important facts—space does not permit. But since New York City does have the largest concentration of persons with AIDS to date, and is an indicator of what a major metropolitan city is doing about AIDS, we thought our readers might find the following excerpts from the Commissioner's speech informative.*

## Planning for AIDS in New York City

As a public health crisis, an economic concern, an issue in the workplace, a sociopolitical phenomenon, and a human tragedy, the AIDS health disaster is profoundly altering this city. Responding effectively and appropriately will test the full measure of our joined social wisdom and courage.

New York City is the North American epicenter of the AIDS epidemic. Since its recognition in 1981, close to 10,000 cases of people with AIDS have been diagnosed in New York City, 30% of the national total. Over half of these people have died. AIDS is the leading cause of death here among men aged 25–44 and women aged 25–29.

Five hundred thousand people are currently estimated to be HIV-infected in New York City. By the end of 1991, over 40,000 people will have developed full-blown AIDS here; 30,000 will have died. More AIDS cases will be diagnosed here in the single year of 1991 than have shown up from 1981 till today. These figures include only AIDS, not other HIV-related infection. The significance of these estimates is clear: the impact of the AIDS epidemic on our citizens, our hospitals, and our entire city will be beyond that of any public health crisis faced in modern times. . . .

## Interagency Task Force on AIDS

To coordinate the City's AIDS programs and services, the Department of Health, the Health and Hospitals Corporation, the Human Resources Administration, the Department of Mental Health, the Board of Education, and the Human Rights Commission have formed an Interagency Task Force on AIDS.

The *Department of Health* program for AIDS education and counseling is a multifaceted prevention and risk reduction effort. On the one hand, it directs education at the general public, health providers, social service personnel, and community organizations; and, on the other hand, it targets information and outreach to people engaged in high-risk behavior.

Information to educate the general population about AIDS goes out in bilingual brochures, flyers, videotapes, wallet

cards, and subway posters. We have been working with two advertising agencies for a multimedia, public health, advertising campaign that will run this spring, hitting the issues of IV drug use and AIDS, and heterosexual transmission risks.

We have begun a \$1 million educational campaign to promote latex condom use, including distributing a million condoms at health facilities, along with educational material. Last week, we joined with the Correction Department in a precedent-setting program to educate jail inmates about AIDS and provide condoms to those at highest risk of infection.

We run specialized training programs to help people incorporate AIDS information into their community and work lives. . . . Special efforts address IV drug users and their sexual partners. Educators are assigned to local areas with the highest incidence of IV drug use to raise community awareness of AIDS prevention, and we work with many city-wide and local organizations, including the community group ADAPT (Association for Drug Abuse Prevention and Treatment), to reach those at risk through IV drug abuse. . . .

The *AIDS Information Hotline* gives anonymous and confidential counseling and information about AIDS and risk behavior, as well as referrals for persons wishing antibody testing. We have also significantly increased the availability of testing for the presence of HIV antibodies. . . .

Since the beginning of the AIDS epidemic, the *Health and Hospitals Corporation* has provided AIDS-related assessment, direct inpatient and outpatient medical care, and extended care services. HHC programs, for people with AIDS, include interdisciplinary health care teams to treat people with AIDS at HHC hospitals that see the largest number of people with AIDS. . . . Bronx Municipal Hospital has the nation's first day-care center for children with AIDS.

The *Human Resources Administration* provides emergency shelter, and assists in housing-related matters, as well as AIDS-related problems with family and children's services. A special social service unit assists persons with AIDS or an AIDS diagnosis in all hospitals. HRA also runs an *AIDS Helpline* for information on public assistance, food stamps, and home care for persons with AIDS or AIDS-related conditions. Recently, Bailey House opened, funded by HRA as the city's first group residence for New Yorker's who lost their housing because they have AIDS.

The *Department of Mental Health* is developing outpatient clinics and day-treatment services for persons with AIDS, as well as family and friends affected by the AIDS crisis. The *AIDS Discrimination Unit of the New York City Human Rights Commission* is handling an increasing number of complaints of AIDS-related discrimination; last year the Unit received 314 complaints, up from three complaints in 1983.

## Critical Policy Issues

Against this background of response, and as the epidemic spreads, a number of public health policy issues are emerging as critical.

*First, public education efforts need to be intensified without creating irrational anxiety and hysteria.*

The most effective way currently to contain the spread of HIV infection in New York City is through a massive and explicit public health education program that gives *everyone* — not just those formerly considered to be in high-risk groups — the information and skills to avoid risky behavior. People *can* protect themselves against getting, and giving, AIDS. We must discuss AIDS issues appropriately, facing the facts we know about AIDS squarely, with honesty about our areas of uncertainty, and in explicit, understandable, and repeated language.

*Second, vigorous public health actions need to be increased while resisting ineffective measures of social control.*

Pressures are mounting for measures such as universal or mandatory AIDS antibody screening programs. Virtually all public health officials, from areas of highest AIDS prevalence, are agreed that forcing people to learn their serostatus when no treatment is available, and unless confidentiality can be assured, would be unwise and counterproductive.

*Third, increases in available resources for research and education must augment the broad range of clinical, public health, and social service needs.*

The federal government has been reluctant to propose an adequately funded federal response to AIDS. It must do much more to support the unprecedented demand for AIDS resources, without sacrificing research and education efforts.

## Translating Policy into Action

To translate these policy issues into measures for controlling the spread of AIDS in the current absence of effective treatment, we must do the following:

*We must rapidly and extensively increase confidential, voluntary risk reduction counseling and HIV antibody testing.*

Counseling and testing assist people to assess their risk for HIV infection, understand their HIV antibody status, and incorporate that knowledge into their behavior. It is our policy that anyone should be able to know his or her antibody status, *provided* the test results are confidential, testing is voluntary, and counseling is available before and after testing. Good medical practice requires these conditions because the test results can have a devastating impact. Individual physicians have the responsibility to *actively* consider if their patients are at risk of AIDS infection, discuss risk-avoiding behavior as part of *routine* medical care of all patients, and offer counseling and, if appropriate, testing to patients at risk.

Testing is available in New York City through free, anonymous counseling and testing sites established in the city by the City and State Health Departments, through any licensed physician in New York City, and at Department of

Health Sexually Transmitted Disease clinics. By the beginning of this year, the Department of Health's HIV counseling and testing programs had served over 18,000 people.

To support the confidential voluntary aspects of counseling and testing, we have adopted a course of action known as contact notification. With this approach, we are urging, and directly and actively assisting when asked, people who are seropositive to notify their contact.

*We must increase massive public health education risk reduction efforts.*

. . . . We need more media programs on AIDS services and risk reduction. No single channel or mode of information will be adequate. We need to use all means at our disposal. The schools must play an increasingly active role.

*We must increase access to substance abuse treatment programs for IV addicts.*

*We must increase efforts to expand our knowledge base.*

. . . . We need to continue to investigate the nature of HIV and its transmission, as well as assess the impact of risk reduction messages on behavior change.

*We must eliminate the false dichotomy between civil liberties and public health.*

Stands on issues such as mandatory antibody testing have at times been portrayed as sacrificing public health in the name of civil liberties. Yet virtually all public health officials agree that public health would be hindered by control measures such as mandatory testing. HIV-infected people — already facing devastating discrimination in housing, employment, and insurance — would not cooperate with our counseling, education, and testing if they feared measures that could lead to additional discrimination.

*Finally, we must increase funding at the federal, state, and local levels.*

. . . . We need to make our confidential, voluntary HIV counseling and testing programs much more widely available, but this will require substantial investments in money and trained personnel. We need more support at the federal and state levels for the massive public health education and risk reduction efforts that are under way and that are necessary to make more people aware of their risk.

The darkest days are still ahead of us. The recent federal approval of AZT is a welcome arrow in our quiver. But biomedical research, though crucial, will not eliminate the problem of AIDS in the short run. We know that no vaccine or therapeutic "magic bullets" are on the near horizon.

But we also know that no major scientific breakthroughs are required to limit the spread of the AIDS virus. We already understand that education on risk reduction, counseling, and confidential, voluntary testing will remain our critical weapons in the fight against AIDS for at least the next several years. Those of us in a position to influence policy must do all we can to advance these weapons against this major and mounting health problem in New York City, across the United States, and around the world.

# News . . .

## National Family Sexuality Education Month

During October, SIECUS will join with 37 other co-sponsoring organizations in celebrating the 13th Anniversary of National Family Sexuality Education Month, a yearly event organized by Planned Parenthood Federation of America.

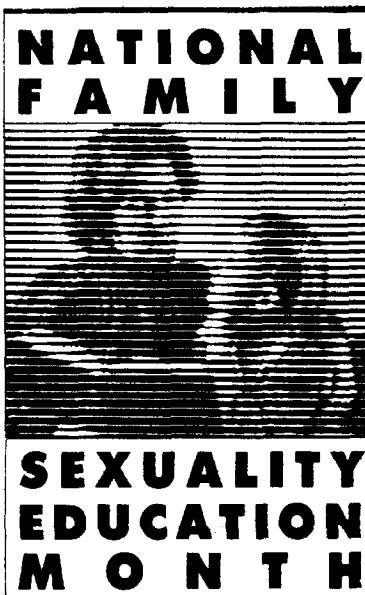
Organizations throughout the country will sponsor a variety of special events and activities to encourage parents in their role as primary sexuality educators of their children; to help families share their values and feelings about sexuality and relationships; and to encourage parents to be open to their children's questions and concerns. Planned are film festivals, teen health conferences, library displays, open houses, family-oriented workshops, advertising campaigns, and other activities.

In addition, a national television and radio public service campaign, featuring Grammy-awardwinning singer, Anita Baker, has been planned. "It's great when families can talk about love and sex . . ." says Baker on one of the spots.

The campaign will emphasize that it is good to be smart about sex, to know the facts, and to talk with someone who knows what is happening—an informed older brother or sister, parents, or organizations that can help. As PPEA President, Faye Wattleton, has stated, "The need for parents to talk with their children about these sensitive subjects has never been greater."

## Attitudes About Birth Control Methods Dictate Contraceptive Practice

Findings from a recently completed study by the Alan Guttmacher Institute, "Barriers to Contraceptive Use," by Jane Silverman, Aida Torres, and Jacqueline Darroch Forrest published in the current issue of *Family Planning*



*Perspectives* (19:3, the bimonthly professional journal of the Institute) indicate that almost half of all unintended pregnancies in the United States, each year, occur to a small proportion of women at risk of pregnancy who do not use contraceptives.

Nearly one-quarter of the sexually active low-income and minority women surveyed in this new study were not practicing birth control. More than half gave reasons based on concerns about method side-effects, or dislike of available methods. Notably, less than 10% of the nonusers gave reasons related to the availability, accessibility and/or affordability of contraceptive services themselves.

Of the approximately six million pregnancies in the United States, each year, more than half are reported to be unintended and about 1.6 million end in abortion. These figures represent levels of unintended pregnancy and abortion that are among the highest in the Western World. However, once women decide to use more effective, prescriptive methods, the report says, they may be hindered in obtaining

them from their preferred provider by issues of cost convenience, and quality of care (which for most women surveyed meant personalized care). The study determined that the primary barrier to clinic use is the apparent belief of many women that clinics do not offer personalized care and that they provide lower quality care than private physicians. The primary barriers to the women's use of private physicians for family planning services are the high cost of such services, and the fact that doctors are less likely than clinics to accept reimbursements from Medicaid or Medi-Cal.

The authors note that since it is doubtful that any new contraceptive method will be approved by the Federal Drug Administration and manufactured in the United States, in the near future, more accurate information and education about the benefits, risks, and effectiveness of available methods, with special emphasis on the pill, is clearly needed. They also note that a number of concerns about the condom persists and these need to be dispelled as well.

## National Directory of Teen Pregnancy Planned

The Women's Action Alliance is presently compiling names and addresses of teen pregnancy prevention programs for inclusion in a state-by-state directory of effective and promising intervention strategies. Included will be narrative chapters on program models; resource materials; organizations that can provide literature and assistance; and information gained from frontline service providers. The Teenage Pregnancy Prevention Directory (TAPP) is addressing a need for single-source reference guide that can quickly and easily be consulted. Service providers and coalition/network coordinators are encouraged to contact Marcia Press or Ro-Ann Cowell as WAA, 370 Lexington Avenue, New York, NY 10017, (212) 532-8330 to add their teen pregnancy prevention efforts to the mailing list for directory questionnaires. Responses to the questionnaires will provide the database for the directory.

## **Survivors Talk About Fighting AIDS**

"Forget the media coverage that tells you AIDS is 100% fatal," said Louis Nassaney, who four years ago was diagnosed with AIDS and was told that he had six months to live. Nassaney is one of a growing number of people "who have beaten the odds that doctors once set for them" according to Alyson Publications.

Many of those, thus far, who are surviving are attributing their success to their mental attitudes. "You have to have the fight inside to determine that you are going to make it—regardless," says Bill Zarieur, a healer involved with PWAs (People With AIDS). Another survivor, Steven Fox, was diagnosed as having AIDS in February, 1985. "When I walked out of my doctor's office (after the diagnosis)," recalls Fox, "I was determined to discover a way to get better and to live." Now, he reports that he feels healthier than before his diagnosis. In his soon-to-be-published book, *Something's Working: One Man's Approach to Healing AIDS* (Boston: Alyson Publications, Inc.), he describes the nutritional therapy, visualization, rolfing, and other healing techniques he has used in fighting AIDS.

It's too early to tell just what the long-range future holds. But for many PWAs, the benefits of a positive attitude are best measured in the present. "Get the quality of your life intact and don't worry about the quantity," urges Louis Nassaney. "Be happy."

## **Cooperative AIDS Publishing Effort Planned**

*You Can Do Something About AIDS*, a 60-page illustrated booklet, is being prepared as a nonprofit cooperative effort, by a number of publishers and writers, for distribution next spring, free of charge. Sasha Alyson of Alyson Publications, who is coordinating the effort, said that "the booklet will emphasize the wide range of ways that people can help fight AIDS." The point of the booklet is to encourage people to get involved and to give people who assume there is nothing they can do some ideas; help in getting started; and encouragement in thinking creatively about the options which

are open to them to help in the fight against AIDS. "Some of the ideas will be relatively obvious... others will be less obvious..." Alyson added: "We've got a lot of ideas already, but we need more." He asks publishers and others who would like to endorse or help fund this project, and those who wish to offer their expertise or suggestions, to write him at Alyson Publications, 40 Plympton Street, Boston, MA 02118.

## **AAPHR Issues AIDS-related Positions Statements**

The American Association of Physicians for Human Rights, a national organization of physicians and medical students dedicated to the delivery of supportive, unprejudiced, and well-informed medical care for gay and lesbian patients, released a series of position statements that cover concerns central to the AIDS crisis.

In the position statement on education, AAPHR stated "that the only currently available solution to halting the spread of HIV in a democratic society is providing each individual with information which enables them to eliminate behaviors placing themselves or their partners at risk." They stated that the continued emphasis on legal solutions stressing involuntary testing, contact tracing, and quarantine mechanisms will significantly undermine proven effective prevention efforts.

In their position statement on involuntary HIV antibody testing of institutional patients, AAPHR reiterated their stand in opposition to mandatory HIV testing. "In particular, we oppose proposals advocating the involuntary and/or mandatory testing of institutionalized mental health patients as an unnecessary and ineffective procedure which violates the rights of such patients" as embodied in proposals before several state legislatures and public health departments.

In taking that stand, AAPHR maintains that such testing "is unnecessarily invasive and aggressive. It is also fallible, given the substantial risk of false negative test results and the identification of additional viruses capable of producing AIDS which are not detected by HIV antibody tests. The safest approach, which would also be the most humane, is to regard all

patients as potentially at risk of HIV transmission or infection and to educate, manage and treat them accordingly." Copies of the complete AAPHR position statements can be obtained by contacting Pierre Ludington at (415) 558-9353, AAPHR, P.O. Box 14366, San Francisco, CA 94114.

## **"America Responds to AIDS" Campaign**

October 1987 has been officially designated National AIDS prevention Month. A national press event will announce the launching of the National AIDS Information Campaign which has been designed to motivate people to take personal responsibility for understanding and preventing AIDS, and to spotlight the participation of groups and individuals who are working to fight AIDS throughout the country.

The Centers for Disease Control awarded \$4.6 million contract to the advertising/public relations firm, Ogilvy & Mather, to create television, radio, magazine, and newspaper advertising to inform the general public about AIDS prevention. Materials will be reproduced in conjunction with the Campaign staff of CDC's AIDS Information and Education program, and will be used both for the fall campaign and during 1988.

Among the activities scheduled for National AIDS Prevention Month in October—the first scheduled event of the campaign—are: distribution of specially designed brochures on AIDS by the YMCA, through its 200 local organizations, to 13 million members nationwide; the airing of a 30-minute segment, "AIDS and the Black Community," which has been produced by Black Entertainment TV; and an "Americans Who Care" reception in Washington, sponsored by the National AIDS Network.

## **LAMBDA and Others Assail Maintenance of "AIDS List"**

LAMBDA Legal Defense and Education Fund has joined with the New York Civil Liberties Union and the Albany Branch of NAACP in assailing the practice of the Police and Fire De-

parts of Albany, New York of maintaining lists of alleged "AIDS carriers," which came to light recently through accounts in local newspapers.

The three organizations demanded, in a letter to Albany Mayor Thomas M. Whalen III, documents and information relating to the list—especially those that would reveal the origins and purposes of the list-keeping. The letter, signed by Thomas B. Stoddard, Executive Director of LAMBDA; Anne Pope, President of the Albany chapter of the NAACP; and Robert Levy, Staff Attorney with the New York Civil Liberties Union stated: "This inquiry is intended, in part, to clarify the remaining ambiguities about the list-keeping by both departments. We should make it clear that we would find the maintenance of any list of this kind to represent a misguided and ultimately dangerous approach to the very serious issues posed by the AIDS crisis—dangerous not only to the well-being of those persons who, accurately or inaccurately, find themselves on the list, but dangerous as well to the police officers and firefighters who deserve more intelligent and effective guidance concerning appropriate precautions to take with respect to this and to other health risks." The request of the documents was made pursuant to New York State's Freedom of Information Law which requires the public disclosure of any government papers formally requested under the statute, with some exceptions.

Initial information sent in response to the letter by the city of Albany was felt by the group to have inadequately addressed their request, and thus they anticipate that they will have to seek additional documentation.

The practice of keeping lists of those allegedly associated with AIDS makes no medical or practical sense," Stoddard said. "Moreover, it is deeply violative of the American conception of equal protection of the law and individual privacy. He said, "If necessary, we will pursue further legal actions to overturn the list-keeping, and to prevent its reinstatement in the future." LAMBDA, headquartered in New York City, "is the oldest and largest legal organization devoted to the rights of lesbians and gay men, and to people with AIDS."

## Legislative Notes . . .

### Congressional Action on AIDS

According to Majority Whip at Large, Vic Fazio of California, the House of Representatives recently voted to appropriate \$945.4 million for all activities associated with AIDS for the fiscal year 1988. This, combined with funds provided for the Food and Drug Administration in another bill, will bring the sum to \$970 million, he said, an increase of 179.1 million above the President's request, and 475 million over 1987 (a 95% increase).

Funds will be used for: biomedical research into the origin and nature of AIDS, development of effective therapeutics to treat those persons already affected; development of a vaccine to prevent the disease; and information and education programs aimed at the public, school and college age populations, high-risk groups, and health workers to help minimize behavior that risks spreading AIDS.

The House of Representatives also approved a bill, H.R. 2881, calling for the creation of a national AIDS advisory commission. Sponsored by Congressman J. Roy Rowland, this bill will create a 15-member panel to study and make recommendations to Congress concerning national policies and priorities with respect to AIDS research, testing, confidentiality of test results, treatment and care of AIDS patients, and education about the disease. The commission is envisioned as complementing the one appointed by President Reagan on July 23. However, "unlike the presidential commission, this commission will include a number of AIDS experts," said Fazio. The House and Senate will each appoint five of the panel members, and at least eight members of the panel will be required to be "recognized experts in the scientific and medical communities and in legal and ethical issues." This bill must now be considered by the Senate.

On July 30, 1987, Congressman Henry Waxman and Senator Ted Kennedy introduced H.R.3071/S.1575, legislation which would seek to ensure confidentiality of test records and protection from discrimination for those who test positive for the virus that causes AIDS. This bill will establish a federal policy on AIDS testing. It focuses on expanding the availability of voluntary testing and counseling and authorizes \$400 million per year, for three years, for grants to existing health facilities that serve high risk populations, such as intravenous drug users or gay men. It will also establish federal protections of confidentiality for AIDS tests results, regardless of whether the tests were conducted using federal funds, with

civil and criminal penalties for violations. "The bill permits that confidentiality be set aside in cases where a direct medical need to know is established—as with health care workers or sexual partners—in states that operate a 'contact tracing' program." The legislation will also extend protection "against discrimination in employment, housing, public accommodations and government services to those who test positive for the AIDS virus, as well as those who have AIDS." However, "the nondiscrimination provisions could be waived if a health professional determined there was a possibility the virus could be transmitted or if the disease rendered a person unable to satisfy bona fide essential criteria for a particular job, housing, or service."

Fazio said: "I believe the increased appropriation for AIDS as well as legislation such as that introduced by Congressman Waxman represent significant steps forward in our fight against AIDS. Please know of my continued efforts in that fight."

### FPA Shepherds Through New Bill

Family Planning Advocates of New York State shepherded through a new

## Conference/Seminar Calendar

bill recently which received unanimous support in both houses.

Since the mid-1960s, New York State Public Health Law has required the names of mothers and, if possible, fathers to be reported on all fetal death certificates for spontaneous and induced abortion. Certificates were filed in triplicate with local registrars, who stored one copy and sent the others to the State Health Department and the local health officer. The name was only deleted from the latter.

Because of increasing harassment and violence against local abortion providers, the photographing of patients entering clinics, and the recording of their license plate numbers, there was concern that "zealots" might attempt to get the names of women from the certificates filed with local registrars. To prevent this, the bill that was drafted eliminates *all* patient identification information from the local registrar's purview. When the law goes into effect in January 1988, the fetal death certificate will be sent directly to the State Health Department, and local registrars will receive only notification that it was filed and the statistical information that is to be forwarded to the county health officer. No name or address will appear on either form. Also, for the first time, there will be protection *in statute* against disclosure of the information in fetal death certificates.

### **Be Educated—Be Prepared**

*"Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth."*

*—from Surgeon General  
C. Everett Koop's  
Report on Aids*

**CLINICAL INTERVENTION IN CHILD SEXUAL ABUSE,**  
*November 2-4, 1987.* Cleveland State University, Cleveland, OH. Co-sponsored with the Witness Victim Service Center, Board of Commissioners of Cuyahoga County, and Cleveland State University (Carla Kolegot, 216-443-7343). *December 1-3, 1987.* Scottish Rite Memorial Temple. Co-sponsored with the Sacramento Child Sexual Abuse Treatment Program (Susan St. George, 916-381-0165). Contact: Dorothy Molis, Administrator, Forensic Mental Health Association, 29 Linwood Street, Webster, MA 01570, (617) 943-3581.

**THE 4TH NATIONAL CONFERENCE ON SCHOOL-BASED CLINICS, "SCHOOL-BASED CLINICS: PUTTING THE PIECES TOGETHER FOR YOUTH," November 4, 1987.** Kansas City, MO. Contact: Support Center, Center for Population Options, 5650 Kirby Drive, Suite 203, Houston, TX 77005-2443, (713) 664-7400.

**THE 30TH ANNUAL MEETING: THE SOCIETY FOR THE SCIENTIFIC STUDY OF SEX, "THREE DECADES OF SEX RESEARCH AND BEYOND: PUBLIC POLICY, FREEDOM OF INQUIRY, SCIENTIFIC ADVANCEMENTS," November 5-8, 1987.** Westin Peachtree Plaza, Atlanta, Georgia. Contact: Deborah Weinstein, MSW, Executive Director, SSSS, P.O. Box 29795, Philadelphia, PA 19117, (215) 782-1430 or Kenneth George, EdD, Chair, 1987 Annual Meeting, UP/Graduate School of Education, 3700 Walnut Street, Philadelphia, PA 19104.

**COMBATTING CHILD SEXUAL ABUSE: SPECIAL ISSUES, November 9-11, 1987.** El Paso Airport Hilton. Forensic Mental Health Associates. Contact: Norma Reed, (915) 542-0153 or Diane Trombley, 865 Via Esplanade, Punta Gorda Isles, FLA 33950, (813) 637-1770.

**PROGRESS IN IMPOTENCE**  
workshops/seminars, *November 12-14, 1987.* Hyatt Islandia Hotel, San Diego, CA. The Urology Research and Education Foundation, University of California, San Diego School of Medicine and the Office of Continuing Medical Education, University of California, San Diego School of Medicine. Contact: Edith Bookstein, UREF, P.O. Box 2586, La Jolla, CA 92038, (619) 454-3212.

**1987 ANNUAL CONFERENCE PROGRAM: "FAMILIES IN AN INFORMATION ERA," November 14-19, 1987.** Westin Peachtree Plaza Hotel, Atlanta, Georgia. Includes many workshops relating to various aspects of sexuality, sexual abuse, gender, and AIDS. Contact: National Council on Family Relations, 1910 West County Road B, Suite 147, St. Paul, MN 55113, (612) 633-6933.

**FAMILY PLANNING ISSUES, November 18, 1987; SEXUALLY TRANSMITTED DISEASES, December 2, 1987.** New Haven Inn and Conference Center. Contact: The Center for Sexual Health and Education, 264 Amity Road, Suite 212, Woodbridge, CT 06525, (203) 387-9061.

**THE FOSTER CARE PROFESSIONAL: CONFRONTING THE CHALLENGES OF 1988** (National Conference), *January 11-15, 1988.* More than 50 training workshops. Among confirmed speakers are Dr. Sylvia Hacher, an expert on sexual abuse among foster care clients, and one of the workshop topics will be adolescent sexuality. St. Petersburg, FLA. National Institute for Alternative Care Professionals, American Youth Work Center, Eastern Michigan University. Contact: Jim Kale, (419) 227-8837 or Bill Treanor (202) 785-0764.

# Book Reviews • Book Reviews • Book Reviews

**LOVE & SEX AFTER 40: A GUIDE FOR MEN AND WOMEN IN THEIR MID AND LATER YEARS.** Robert Butler and Myrna Lewis. New York: Harper & Row, 1986 (192 pp.; \$15.95).

Those of you who are familiar with *Sex After 60*, written by the authors ten years ago, and now out-of-print, will welcome this new offering—even though it includes much of the original book.

The focus of their new book is on recognizing and treating sexual problems in the mid years *before* they become major disturbances in the later years. Three new chapters in this new book present the latest medical and scientific information on physically-caused impotence; on estrogen anxiety associated with menopause; and on the sexually transmitted diseases of AIDS, herpes, and chlamydia.

Also, the chapter on common medical problems has been expanded to include a discussion of the effects of coronary bypass surgery, hypertension, and chronic cystitis on sexual functioning. In addition, the chapter which focuses on the sexual effects of surgery on sex organs offers some very helpful advice on resuming normal sex life after hysterectomy, mastectomy, or prostatectomy.

Those of you who are not familiar with the first book will find this one most informative on the physical aspects of sexual problems in the mid and later years. The authors emphasize, throughout their discussions, the importance of talking about the sexual aspects of physical problems and also provide specific questions that one should ask one's doctor or counselor.

The topics which deal with psychological issues offer a number of strategies for enhancing sexuality after forty, but do seem to be geared toward the later years. These topics include: tips for lifelong sexual fitness; the second language of sex; problems with partners; dating, remarriage and your children; and where to go for help. One good bit of advice they offer is to avoid doctors who quickly dismiss

sexual concerns with: "What do you expect at your age?"

The decisions to publish *Love & Sex After 40* was due, in part, to the realization that those in midlife—people in their 40's and 50's—also, as do those over 60, worry about body changes, impotence, loss of sexual attractiveness and of partners. Moreover, the authors felt, that in today's climate of greater acceptance of midlife sexuality, individuals with such concerns might be more successful in dealing with them if they knew what to look for and where to go for help.

Since midlife people now speak more freely about sex, and do seek medical and psychological help, earlier recognition and treatment are possible; and because of significant improvement in medical diagnosis, surgical procedures, drug administration, and treatment of acute and chronic illness, many of them are being led to better and more satisfying sexual functioning.

One of the new chapters, as mentioned before, deals with impotence. It is now estimated that 50% of impotence is caused by physical factors. This is very important, because it indicates that sexual dysfunction is often the result of *disease*—and not of *aging*. Early diagnosis and treatment, therefore, can make sexual behavior a lifelong satisfying activity. History-taking, sleep studies, penile blood pressure, and pelvic arteriography techniques now used for diagnostic purposes are described; and guidelines are offered for determining which men are appropriate candidates for the four types of penile prostheses. The authors also stress the importance of including a man's partner in pre- and post-implant surgery evaluations; and advise counseling for those couples who are not implant candidates. Revascularization, vacuum constriction, and the use of yohimbine are mentioned as alternate treatments for impotence.

This book also provides 19 pages of the latest information on the risks and benefits of the short- and long-term

application of ERT (estrogen replacement therapy) for menopause and post-menopause women. Three tables are presented to indicate contraindications, considerations, and usage in specific deficiency states of estrogen. Menopausal women are urged to become more involved in natural self-help care, by using relaxation techniques, aerobic exercises, and healthful dietary habits to help achieve optimal sexual functioning. The authors list quite a long number of topics that will require further study if women and their physicians are to make intelligent decisions regarding estrogen replacement therapy. It is their opinion that the risks, and benefits, of this therapy are not yet completely resolved.

The expertise of the authors is reflected in the quality of the material presented. Dr. Butler is chairman of the first department of geriatrics to have been established in an American medical school. Ms. Lewis, a social worker/psychotherapist, has a special interest in the social and health issues of midlife and older women.

*Love & Sex After 40* is important reading for the general public—of all ages. It is especially important, however, for people *after 40* to have accurate, and up-to-date, scientific information so that they can continue to engage in satisfying sexual behavior for as long, and as often, as they choose. The book provides valuable material for physicians, therapists, and other healthcare providers as well.

Although the book deals competently with many aspects of sex after forty, additional references should be explored for a more in-depth study of the psychological factors and social skills that also contribute to satisfying relationships for midlife couples. A, PR

*Reviewed by Miriam Schneider, EdD, associate professor of health education, York College of the City University of New York, and AASECT-certified sex educator.*

**SEXUAL AROUSAL.** Miguel Fischer, Ralph E. Fishkin, and Joseph A. Jacobs. Springfield, IL: Charles C. Thomas, 1984 (271 pp.; \$29.50).

In this era of scientific advances and rapid change, there is need for periodic reviews and books that summarize our present status and point the way for future advances. This is particularly true in certain fields that cut across the usual disciplinary boundaries, and involve experts of different sorts, who do not regularly study one another's literature. *Sexual Arousal* is such a volume: consisting of 15 chapters by 29 authors.

Most of the contributors come from Philadelphia or New York, but there is little indication of insularity in the material they present. They are knowledgeable, and most are engaged in research in the areas they write about. In general, the information they present is accurate; and even complex material is interestingly and understandably presented. This is, however, not the place to find the latest information on a particular subject. The volume was published in September, 1984, and there are few citations more recent than 1981. There is a passing reference to, but no discussion of, the "Grafenberg Spot" and "female ejaculation," and no mention of AIDS and the enormous impact it has had on sexual relationships, including arousal.

The book is well-organized. It opens with reviews of male and female sexual physiology, and with additional chapters on psychology and endocrinology; Part II presents modern diagnostic procedures; Part III deals with treatment; Part IV is a rather lengthy chapter on the sexual dysfunctions of male diabetics; and Part V deals with disability, aging, drugs (chiefly alcohol), and heart disease. An earnest attempt has been made to give equal attention to the problems of women, but this has been frustrated by the paucity of scientific studies on female sexuality. Many chapters apologetically focus on male erectile difficulties, just because so much more is known about them than about female lubrication and orgasm. The emphasis, throughout, is on heterosexual relationships, again reflecting our knowledge base. Gay readers might

have appreciated a few sentences explaining that, while physiological responses are similar in homosexual encounters, little is known about the physiology of anal intercourse; and there are many, complex, physiological factors that influence homosexual responses that are also poorly understood.

In putting together a volume like this, an editor naturally seeks outstanding experts in each field but, if successful, he then tends to lose some of his editorial prerogatives, since such experts often do not want their writing tampered with. These chapters are only loosely connected to each other; there are occasional, unnecessary duplications and a few, unexplained, contradictory opinions. One of these relates to the meaning of the title of the book. Using his DAVOS acronym, Harold Lief elegantly dissects out the meaning of "arousal," differentiating it from "desire," on the one hand, and from the vasocongestive, physiological phenomena of erection and lubrication, on the other. He states that, "arousal refers to the psychic aspect . . . of excitement" only, but most of this book is concerned with the physiological aspects.

It is useful to have, between two covers, this collection and analysis of scientific information about different aspects of sexual arousal. At the same time, I was left dissatisfied, feeling that most of these blind men, describing an elephant, are also deaf and anosmic. At the present time, science cannot give an accurate picture of sexual arousal; we need the help of philosophy, poetry, religion, etc. *Sexual Arousal* says little about intimacy, romance, love, and trust; or about anger, hate, fear, and jealousy. Some couples find pornography useful in arousing sexual feelings; others are into dominance and submission, and a wide variety of paraphilic. Anecdotal reports suggest that pheromones may be important in humans. Philadelphian, Timothy Perper, has just written *Sex Signals: The Biology of Love* (see review in *SIECUS Report*, Nov.-Dec., 1986), a book about courtship and communication, but his work is not cited among the 399 references given. Many important aspects of human sexuality are not amenable to laboratory study, and they are not adequately dealt with

in *Sexual Arousal*. This book admirably covers part of the picture, but it leaves other parts untouched. I wish that Paul Fink's opening chapter had been expanded.

One always hopes that when a lot of experts in different, but related fields, assemble their ideas, a striking, new insight will emerge. No such revelation was apparent to this reviewer; perhaps other readers will be more receptive or perceptive. A, PR

Reviewed by Richard J. Cross, MD; emeritus professor, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School; member of the board of directors, SIECUS.

**NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880.** Allan M. Brandt. New York: Oxford University Press (1985; 245 pp.; \$8.95 pap.)

July of 1986 marked the historic rededication of the Statue of Liberty and, ironically, the Supreme Court decision to uphold the Georgia state sodomy law. The intent of the Court seems to be the control of homosexual behavior and, perhaps, the spread of the AIDS virus through the legislation of a certain moral code. In order to understand this, and many other decisions currently being made about AIDS and other STDs, I recommend reading *Magic Bullet* by Allan Brandt.

Brandt's work is an illustrative history of the incidence of venereal disease in the United States since 1880, and of the programs designed to combat its spread. Government funding for such programs was strongest during the two World Wars.

Brandt points out the continuing conflict between the moralist and the scientific approaches to treatment and prevention, beginning with the theory of contamination (by which men were believed to be made ill by women, because of their innate possession of disease) through to the discovery of germ theory.

While the rise and fall of the incidence of venereal disease has often been spoken of in connection with morality, it has also been connected with a multitude of factors, not the least of which are public and social health programs which provide education, prophylactic measures, treatment and follow-up. What Brandt calls "the conspiracy of silence" is a belief, held by some, that if we completely eradicated V.D. it would lead to immorality because of the removal of the fear factor in limiting behavior. Brandt argues that this conspiracy of silence has actually been a strong social force that has curtailed effective prevention and treatment of V.D. in this country.

Published in 1985, the scant information presented on AIDS is already obsolete, but the historical perspective and philosophical orientation of the text is very timely and will, hopefully, allow all of us to profit from a greater understanding of our history. Recommended for professionals and adults interested in STDs. A, PR

*Reviewed by Peter B. Anderson,  
doctoral student, New York University  
Program in Human Sexuality.*

**SEX AND THE SINGLE PARENT:  
HOW YOU CAN HAVE HAPPY  
AND HEALTHY KIDS—AND AN  
ACTIVE SOCIAL LIFE.** Mary Mattis, PhD. New York: Henry Holt, 1986 (316 pp.; \$16.95).

Presently, one out of every two marriages ends in divorce; and one out of every four families is headed by a single parent. With the number of single parent families increasing, there is a growing need to provide information and guidance to assist those who are raising children alone in re-entering the world of the unmarrieds.

Mary Mattis' new book, *Sex and the Single Parent*, is the latest resource for single parents who are trying to adjust to family life changed by death, divorce, or separation. The book's subtitle, "How You Can Have Happy and Healthy Kids—and an Active Social Life," points out the focus of the book; and the 16 chapters—and a section on resources—further testify to the work's thoroughness.

Mattis, a psychotherapist, who was raised by a single parent, currently counsels parents and children in a psychiatric clinic. She bases *Sex and the Single Parent* on her interviews with single parents and their children, and on the works of recognized writers in the field of single parents and children: Erick Erikson; Wallerstein and Kelly; Janice Nadler; Carol Colman; Jacqueline Simenauer and David Carroll; Elissa Melamed; Richard Gardner; Brian Miller; Betty Berzon; Garnett E. Phibbs of Parents Without Partners; and more.

The opening chapter identifies six problems faced by single parents: guilt about wanting to have a private adult life; fear of socializing; playing the "superparent"; using the children as a substitute for adult companionship; nonacceptance of one's own sexuality, or of sex in general; and discomfort with already-made decisions.

The book follows a fairly consistent analysis in its presentations, interspersing the factual portions with short case histories to keep the reader in touch with the actual realities of the situations presented. It also provides specific guidance for the unique problems encountered in raising children alone, such as: helping children to understand a parent's need for a social life and coping with those children who sabotage it; babysitting problems; sex education issues; dating and sexual dilemmas; how to include a lover in one's family life and help this lover to understand one's children; and how to deal with the ex-spouse, and extended family.

*Sex and the Single Parent* is especially commendable for the inclusion of a chapter which focuses on "Unconventional Life-Styles: Special Concerns of Parents with Alternative Life-Styles." Unconventional single parents—homosexual parents, elective single parents, and single adoptive parents—face special problems: those related to their life-styles and those caused by societal attitudes towards them. Few resource books have directly addressed these parents to date.

Overall, this book is commended for its practical suggestions for single parents on how to combine an active social life with a supportive home-life. However, some things could be improved. For

example, the \$16.95 price of the book is prohibitive for many single parents, especially women: while divorce is generally financially profitable for men, it is often an economic disaster for women with children. Also, the book could be condensed. Often, a single parent must juggle work, children, and household chores with little time for relaxation. Therefore, a shorter book, with fewer case histories, would not only be less expensive, but also could be read more quickly and easily. Mattis also omits cultural and religious differences which can, and often do, affect the problems faced by single parents. However, this may have been beyond the scope of the present book.

On the whole, the book is a practical and supportive guide, and resource, on sex and the single parent—one which is unusual for its combination of theory and "how you can" information. P

*Reviewed by Brenda Kaufman-Dressler, PhD, health education teacher, Bayside High School, Queens, New York.*

**GENDER ISSUES, SEX OFFENSES AND CRIMINAL JUSTICE: CURRENT TRENDS.** Sol Chaneles, editor. New York: Haworth Press, 1984 (170 pp.; \$22.95)

The editor of this book has compiled articles on a variety of topics, including adjustment to prison life, CB radio prostitution, and rape and racial patterns.

The articles can be grouped into two main categories: female offenders and rape. Those focusing on female offenders cover diverse topics: for example, an article on bail-setting practices indicates that males arrested for prostitution offenses are released more quickly than female prostitutes; in another article, it was found that an intervention support group can facilitate female offender's adjustment to prison life. The articles on rape discussed strategies to reduce sex-related violence in prison, and offered a review of available literature on rape—unfortunately little of which is new. For those interested in juvenile delinquency, two articles focus on female delinquency, a neglected field of research.

Because most of the topics discussed in this book are special problems in law

enforcement, which deal with social control, I would not recommend this book to mental health and human sexuality professionals. However, the articles will be of interest to those, in the legal and criminal justice system, who work directly with, or counsel, offender populations.

*Reviewed by Meg Kaplan, PhD, research scientist, Sexual Behavior Clinic, New York State Psychiatric Institute; instructor in clinical psychology, Columbia University, College of Physicians and Surgeons.*

#### Book Briefs

**THE ANTIPOGESTIN STEROID RU 486 AND HUMAN FERTILITY CONTROL.** Edited by Etienne-Emile Baulieu and Sheldon J. Segal. New York: Plenum Press, 1986 (353 pp.; \$29.50).

This book provides the full reports of clinical trials with RU 486—a new drug that may be used to terminate early pregnancy. It gives the results of experiments using RU 486 to induce abortions in rats, monkeys, and women—and studies of RU 486's possible use in the diagnosis and treatment of cancer and some metabolic diseases. RU 486, developed by researchers at INSERM and Roussel-Uclaf in Paris, France, has been extensively tested for the last several years. The book, edited by Etienne-Emile Baulieu of the University of Paris-Sud, and Sheldon J. Segal of the Rockefeller Foundation in New York City, contains papers presented at a worldwide conference on RU 486 held in Bellagio, Italy, in 1984.

**THE LANGUAGE OF SEX FROM A TO Z.** Robert M. Goldenson, PhD. and Kenneth N. Anderson. New York: World Almanac, A Walter D. Glanze Book, 1986 (314 pp.; \$19.95).

Badly needed and "the first of its kind," this dictionary of sexology defines nearly 5,000 terms from the scientific to slang. Besides technical terms, it includes colloquial expressions and background material drawn from leading contributors and specialists and is meant to provide the reader with insight into every area of sexuality. It covers "all key elements of the new scientific discipline of sexology, which includes the sexual aspects of anatomy, physiology, anthropology, sociology,

psychoanalysis, psychotherapy, genetics, medicine, linguistics, and the legal and moral issues of our times." It includes physical and psychological disorders of sex, scientific sex studies, sexually transmitted diseases and remedies (including 30 entries on AIDS); sexual practices around the world and throughout history; sex and marriage therapy; sexual devices; folklore and superstition; pregnancy; abortion; childbirth, biographies of great contributors; quotations from literature (including Shakespeare's sexual terms); sexual taboo words and their origins; erotic techniques, stimulants and aphrodisiacs, obsolete but fascinating sex words; and social change reflected in the language of sex. One disappointment: delighted to have such a helpful resource on hand, we were asked for a good definition of sex therapy or therapist and thought let's try our new dictionary. Guess what—no listing, but SIECUS is listed!

It's hard to be perfect the first time; useful omissions will probably be filled in the next time round. Goldenson is the author of many books, including *The Wonderful Human Machine*, *The Lawyer's Medical Encyclopedia*, and *The Miracle of Life*. Anderson is a clinical psychologist and psychotherapist, and member of the faculty of New York Medical College.

**LEARNING ABOUT SEX: THE CONTEMPORARY GUIDE FOR YOUNG ADULTS.** Gary F. Kelly. Woodbury, NY: Barron's, 1976, 1977, 1986 (195 pp.; \$6.95 pap.)

This is the third revision of a popular illustrated book by the well-respected sex educator, Gary Kelly, which can be used as a textbook or as a book that young adults can read on their own. The book, reviewed when it first came out in the SIECUS Report, was called "a vital beachhead in the ongoing struggle for sexual sanity..." by our reviewer. It was also voted onto the Best Books for Young Adults List by the American Library Association. The revised edition has additional information on homosexuality, bisexuality, alternate forms of relationships, sex outside of marriage, herpes, AIDS, and the latest findings on birth control methods. It contains a glossary of sexual terms, including slang expressions. Please note, however, that in listing some resources, the book gives an old and incorrect address for SIECUS.

#### TRANSSEXUALISM AND SEX REASSIGNMENT

Edited by William A. W. Walters and Michael Rose. New York: Oxford University Press, 1986 (191 pp.; \$27.95).

A general overview of transsexualism that has evolved out of the experiences of the Australian editors and contributors. Just over 100 male-to-female complete gender reassignment procedures and 17 female-to-male partial gender reassignment procedures have been carried out at their gender identity clinic (established in 1976) at Queen Victoria Medical Center in Melbourne. The book deals with various factors that determine gender identity and describes how and why transsexualism develops. It also considers means of managing the condition and the processes involved in gender reassignment (sex change). "While several aspects of the book relate primarily to Australian conditions, the major part is relevant to transsexualism in all parts of the world."

#### Sex Education

*"Education about AIDS should start in early elementary school and at home so that children can grow up knowing the behavior to avoid to protect themselves from exposure to the AIDS virus. The threat of AIDS can provide an opportunity for parents to instill in their children their own moral and ethical standards.*

*Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility . . .*

*Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases."*

*—from Surgeon General C. Everett Koop's Report on AIDS*

# Audiovisual Reviews • Audiovisual Reviews

**NORMA AND TONY: FOLLOWING SAFER SEX GUIDELINES.** 1985, video, 30 min. Purchase, \$150; rental, \$25. Multi-Focus, 1525 Franklin Street, San Francisco, CA 94109; (800) 821-0514; (415) 673-5100 (CA only).

Norma and Tony, who have been friends for years, talk about wanting to have sex with one another. They each disclose their sexual histories. Tony's includes having sex with other men, using intravenous drugs, and sharing needles. Norma's includes a 10-year marriage and experimentation with group sex. They make a shopping list of what they will need to engage safely in the sexual practices in which they are interested. Together they purchase hydrogen peroxide (for gargling), condoms, contraceptive sponges, a spermicide, a lubricant, rubber gloves, and latex squares.

Norma and Tony begin their lovemaking by taking a shower together. Tony expresses concern about Norma coming into contact with his preseminal fluid, and Norma puts a condom on him to prevent this. Tony inserts a contraceptive sponge (not wet, as it should be) into Norma. Then he inserts spermicide into her vagina, puts on a rubber glove, and rubs lotion on her vulva. Wearing a glove, Norma stimulates Tony's rectal area. Tony covers Norma's vaginal area with a latex square stretched across a circular frame and, through it, stimulates her clitoris.

As described above, this film may appear to provide a much-needed guide for heterosexuals on safer sex. Unfortunately, quite the opposite is true. Norma and Tony are not role models with whom the average person can identify, as their manner of speaking and lifestyle seem to represent a California counterculture and not the mainstream. The film is intimidating, with too many risk groups represented, too many safer sex products purchased, and too many sexual practices tried. Above all, there are too many unconvincing exclamations from Norma and Tony about how erotic they are finding their lovemaking to be. The Audiovisual Review Panel unanimously

agreed that the film was a real turn-off and that they would not recommend it for any audience.

**THE SUBJECT IS AIDS.** 1987, 16mm or video, 18 min. Purchase, \$400 (16mm), \$325 (video); rental, \$85. \$135 for each additional copy of *The Subject is AIDS* or *Sex, Drugs, and AIDS*. O.D.N. Productions, 74 Varick Street, New York, NY 10013; (212) 431-8923.

This revised version of O.D.N.'s *Sex, Drugs, and AIDS* (see review in the September 1986 *SIECUS Report*) was inspired by requests from the Surgeon General, as well as from educators and parents, for a film stressing abstinence as a primary form of AIDS prevention. The new film, still narrated by Rae Dawn Chong, incorporates segments from the original one, including the explanation that AIDS cannot be contracted casually but only through sexual contact, or infected blood, and the interviews in which persons with AIDS explain how they got the disease. Blame for AIDS is put exactly where it belongs: on the virus.

Two scenes from *Sex, Drugs, and AIDS* have been eliminated: the three girls at the ballet studio discussing how to protect themselves against sexually transmitted disease; and the bicycle shop-owner talking about how his homophobic attitudes changed when he learned that his brother was gay, and then later watched him die of AIDS.

Three new segments have been added: an opening statement from Surgeon General Everett Koop about the importance of AIDS education; a scene in which three junior high school girls, and two boys, discuss abstinence as a positive alternative and primary means of AIDS prevention; and a scene in which three students, from different ethnic groups, speak candidly about how AIDS has affected their lives. One result of these changes is that *The Subject is AIDS* is, as its title implies, more about AIDS and less about homophobia.

Generally, the Audiovisual Review Panel liked this film, although some

members would have preferred if the bicycle shop scene had been left in. They especially appreciated the shift toward emphasizing shared female and male responsibility for condom use, as opposed to the earlier film's emphasis on girls taking this responsibility. *The Subject is AIDS* seems especially appropriate for younger adolescents. It, and its predecessor, are both recommended depending on the particular needs of the educator and audience. ET, LT, P

**A TOUCHY SUBJECT.** 1986, video, 26 min. Purchase, \$200; rental, \$75. O.D.N. Productions, 74 Varick Street, New York, NY 10013; (212) 431-8923.

In this video, four short dramatic scenes depict parents, in the course of such ordinary events as letting a child go into a public restroom alone for the first time, talking to their children about child sexual abuse prevention. The message to parents is that this type of education can be begun as early as age two; can be done in the course of such everyday events as setting the table; and need not involve total sex education (which many parents do not feel ready to give) simultaneously.

Four messages for parents to give their children are emphasized: your body is yours; you can say "no"; tell me right away; and it is never the child's fault. The sound track features Phoebe Snow singing an original safety song, for children of all ages, entitled "You Can Say No!"

*A Touchy Subject* features a middle-class, ethnically-balanced group of parents and children. The Audiovisual Review Panel's main objection was with one scene, in which the father uses such language as "down there" and "hiney" in the course of asking his son if anyone ever "messed with him." Consistent role-modeling of the use of accurate terms for the sexual parts of the body would have been preferable. However, overall we recommend this video for its solid, simple messages which should reassure parents and inspire their confidence as child sexual abuse educators. P

**RETHINKING RAPE.** 1986, 16mm or video, 26 min. Purchase, \$425 (16mm), \$275 (video); rental, \$45. Film Distribution Center, 1028 Industry Drive, Seattle, Tukwila, WA 98188; (206) 575-1575.

This film attempts to cover a lot of ground, looking at acquaintance rape and its societal causes. It examines cultural attitudes towards women, and questions the influences—such as advertising, sexist jokes, and beauty pageants—which shape these attitudes. Six people share their perspectives on rape. One woman tells of her rape by her boyfriend, followed by longtime embarrassment and the inability to reveal it or to go for counseling. A former model, who was raped during her career, discusses how realization of the kinds of messages she was promoting caused her to give up modeling. Dr. Edward Donnerstein discusses his research which shows that violent pornography makes people more cavalier about rape and a male college student reveals how he nearly raped a good friend.

Although there is much valuable material in *Rethinking Rape*, it was the opinion of the Audiovisual Review Panel that the film is choppy and that its focus is unclear. The title and promotional flyer add to the confusion: The title implies that the film covers rape in general, but the promotional flyer states that it is an in-depth look at acquaintance rape (however not all the rapes described in the film are acquaintance rapes) and an attempt to understand the high frequency of rape in our society. Because of this lack of clarity, the film is neither an in-depth film about acquaintance rape nor rape in general. Some educators may, nonetheless, wish to use it to provoke discussion among fairly sophisticated audiences about different aspects of rape. **IT, A**

**NO TIME SOON.** 1987, 16mm or video, 16 min. Purchase, \$330 (16mm), \$300 (video); rental, \$75. ODN Productions, 74 Varick Street, New York, NY 10013; (212) 431-8923.

This film is the male companion to ODN's excellent teenage pregnancy

prevention film *In Due Time*, told from the point of view of a young urban black woman (reviewed in the September 1985 *SIECUS Report*). In

between having sex and making love and also speak about taking responsibility for their sexual actions.

Vincent and Arty are appealing and articulate, and should serve as excellent role models of young men who have found alternatives to the pressures of unplanned fatherhood. Although the Audiovisual Review Panel generally found *No Time Soon* to be less compelling than *In Due Time*, we recommend it, especially for the audience of young men of color, whom it addresses. The two films together would make a powerful combination. **ET, IT**

## Choices: In Sexuality with Physical Disability

(16 mm & Video/Color/60 Mins.)

Produced for:  
Institute of Rehabilitation Medicine  
New York University Medical Center  
Joan L. Bardach Ph.D., Project Director  
Frank Padrone Ph.D., Co-Director

... Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed...

**Pam Boyle, Coordinator:** Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood. NYC.



*Mercury Productions*  
7 West 18th Street, 2nd flr  
NYC 10011 (212) 869-4073

*No Time Soon*, two young men—Vincent, who is black, and Arty, who is Hispanic—speak frankly, from their experience, about sex, birth control, relationships with girls, school, and how to avoid becoming a teen father. Each of these segments has its own title, making it very easy to use the film in parts.

Vincent has had first-hand experience in caring for children, as he had to look after his younger brother while his parents worked. Arty, who saw his father leave his mother and have children by a number of different women, talks about how ignorant and uncomfortable he was the first time he had sex. Both young men say they get horny but admit that they do not have to have sex every time they feel that way, despite peer pressure to the contrary. They explain the difference

**VICTIM TO VICTIMIZER: BREAKING THE CYCLE OF MALE SEXUAL ABUSE** 1987, 16mm or video, 24 min. Purchase, \$515 (16mm), \$424 (3/4" video), \$399 (1/2" video); rental, \$52. Barr Films, P.O. Box 5667, 3490 East Foothill Boulevard, Pasadena, CA 91107; (800) 423-4483.

This disturbing documentary reveals that many young men who sexually abuse children are themselves victims of child sexual abuse. A number of male adolescent sex offenders—all now incarcerated in California—reveal their own histories of abuse, which include victimization by men, women, parents, acquaintances, and strangers. They talk about molesting children to get revenge, to express hurt, to re-enact what happened to them, and to make someone else feel their pain.

A therapist points out that these troubled men, in their acts of molestation, are expressing their own feelings while denying those of their victims. One of the major objectives of therapy with them is to get them to see the victim as a person, and not as an object. Another is to get them to blame their own misfortune on the person who offended them, and not on themselves.

The Audiovisual Review Panel liked *Victim to Victimizer* for its demystification of adolescent sexual abusers: first, showing that they can appear to be "all-American boys"; and second, that they are victims before they are victimizers. We also appreciated the focus on males as sexual abuse victims of both males and females. One thing that we

*Audience Level Indicators:* C—Children (elementary grades), ET—Early teens (junior high), LT—Late teens (senior high), A—College, general adult public, P—Parents, PR—Professionals.

did not care for about the video was its heavy, and at times even "creepy," music and narration.

This video is recommended as a good consciousness-raiser about a group for whom there has traditionally been little sympathy. Ultimately, however, it raises more questions than it answers, such as: Is this behavior addictive? Why do many more male than female sexual abuse victims turn into offenders? Can intervention and treatment really work? A skilled discussion leader will be needed to help the audience deal with these inevitable questions. **LT, A, PR**

**Note:** A change has been made in *The AIDS Movie* (reviewed in the May/June 1987 *SIECUS Report*), based on one of the criticisms of the film mentioned in the review. The SIECUS Audiovisual Review Panel felt that the film overstated the safety and effectiveness of the condom, giving the impression that it provides 100% effectiveness against STDs, including AIDS. Now the film says that ways to prevent AIDS are to abstain from sexual activity, use a condom, and avoid intravenous drugs.

*Members of the Audiovisual Review Panel for this issue were: Peter Anderson, student, Human Sexuality Program, New York University; Carmen Reyes Aviles, MSEd, Community Family Planning Council, New York City; Patti Britton, Department of Education, Planned Parenthood Federation of America; Heather Gregg, MPH, health educator, Women's Health Program, Department of Health, New York City; Leigh Hallingby, manager, SIECUS Information Service and Mary S. Calderone Library; Hillary Kunins, Department of Education, Planned Parenthood of Bergen County, Hackensack, NJ; Joan Lambert, student, Human Sexuality Program, New York University; Jean Levitan, PhD, assistant professor, Health Science, William Paterson College, Wayne, NJ; Konnie McCaffree, PhD, teacher, Council Rock High School, Newton, PA; Alex Sareyan, president, Mental Health Materials Center, Bronxville, NY; Jan Sola, program consultant, National Board of the YWCA of the USA. The reviews were written by Leigh Hallingby.*

# Other Information

## Resources...

### Abortion

**ABORTION IN AMERICA** (July 1986, 6 pp., newsletter format), written by Judith Levine. Provides facts and statistics on abortion; covers the contemporary legal status of abortion; limited access to and limited freedom to choose abortion; the consequences of criminalizing abortion; opposition to choice; legal challenges in the courts and in Congress; state and local ballot initiatives; violence and harassment; deception and propaganda; keeping it safe and legal; and lists resource organizations. *Zero Population Growth, Inc., 1601 Connecticut Avenue NW, Suite 400, Washington, DC 20009-1035, (202) 332-2200. Single copy free with self-addressed, stamped envelope. Write for bulk prices.*

### AIDS

**AIDS** (1986, 2nd ed., 91 pp., 8½" x 11" bibliography) edited by David A. Tyckoson. "As long as AIDS remains a topic of vital concern, one volume a year of the quarterly Oryx Science Bibliographies series will be devoted to the subject, providing librarians with up-to-date coverage. Each AIDS volume begins where its predecessor left off." Lists and summarizes "only the most important and readily available sources accessible to the undergraduate audience": articles, books and other publications covering all aspects of the disease. "Of special interest to librarians in academic, public, medical, and large high school libraries." *Oryx Press, 2214 North Central at Encanto, Phoenix, AZ 85004-1483, 1-800-457-oryx, (602) 254-6156. Prepaid price: \$15, includes p/b.*

**AIDS AND ADOLESCENTS: RESOURCES FOR EDUCATORS** (July 1987, 6 pp., bibliography) is a new bibliography of AIDS education materials prepared by the education staff of the Center for Population Options, who "reviewed available materials for their accuracy; the attention paid to dispelling myths; and the inclusion of information to prevent infection." Included are curricula; pamphlets; materials for parents; movies; and leader resources. Also available, in bulk, is an *AIDS and Adolescents* fact sheet which was originally distributed at CPO's conference on AIDS and Adolescence ("can be duplicated with prior permission in some cases"). *Education Department, Center for Population Options, 1012 14th Street, NW, Washington, DC 20005, (202) 347-5700 for further information.*

**AIDS AND PREGNANCY** (1987, foldover pamphlet). Provides current information on AIDS and its effect on pregnancy and healthy birth, and additional information on children with AIDS. "Studies have indicated that pregnant women who have been exposed to the AIDS virus may have an increased risk both of developing AIDS and of possibly passing it on to their children during pregnancy, birth or through breastfeeding." *Publications Department, Maternity Center Association, 48 East 92nd Street, New York, NY, (212) 369-7300. Price: \$.50 each; 100+, \$.20 each. Under \$5, no p/b, over, add 5%.*

**AIDS IN NEW YORK CITY: REPORT TO THE MAYOR, APRIL 1987, INTERAGENCY TASK FORCE ON AIDS** (65 pp., 8½" x 11" report). This is the second report, the first was submitted in December 1985, of the Interagency Task Force (six participating agencies) which meets regularly to address AIDS-related issues. Discusses the wide range of programs initiated in New York City in response to the AIDS crisis, and new initiatives for the 1988 fiscal year. Also available at no charge are the pamphlets: *AIDS: What Everyone Should Know; Children and AIDS; Get the Facts . . . Not AIDS; Shooting Up and AIDS; and Women and AIDS*. *Kerry Peltzman, Materials Coordinator, Public Health Education Bureau, 125 Worth Street, Room 203B, Box 46, New York, NY 10013.*

### AIDS AND THE PUBLIC SCHOOLS

(1986, 55 pp., report) is the topic of this quarterly National School Board Association *Readership Report* written by Susan Hooper and Gwendolyn Gregory. The primary objective of this report, which grew out of the National NSBA Conference on AIDS held in February of 1986, is to provide school leaders with: "... a comprehensive review of the medical facts known about AIDS; information about the legal implications of AIDS in the school setting; and an overview of possible school board policy responses to AIDS taken by school districts across the nation." The report also provides information on developing an AIDS policy and an AIDS curriculum, and discusses New York City's AIDS curriculum. *Research and Information Services Department, NSBA, 1680 Duke Street, Alexandria, VA 22314. Price: \$15, s/b charges added for billed orders.*

**AIDS RECORD** (12 pp. *newsletter*), published twice a month will be offering "complete coverage of the AIDS syndrome epidemic": statistics, research, information on organizations, legislation, education, grants and funding opportunities, conferences, etc. *Julie Bres Slavik, 1518 K Street NW, Washington, DC 20005, (202) 393-AIDS.* Price: \$275 yearly subscription, additional copies mailed in the same envelope will be \$75.

#### **AIDS-RELATED DISCRIMINATION IS ILLEGAL IN NEW YORK CITY**

(December, 1986, *foldover pamphlet*) explains what AIDS-related discrimination is and how to recognize it; provides typical examples of illegal discriminatory practices; tells who is protected from AIDS-related discrimination; and explains what the NYC Commission on Human Rights can do about it. **NEW YORK CITY**

#### **COMMISSION ON HUMAN RIGHTS REPORT ON DISCRIMINATION**

**AGAINST PEOPLE WITH AIDS** (Volume I, November 1983-April 1986, 21 pp., Volume II, January 1986-June 1987, 30 pp. reports). Provides detailed and summarized accounts of AIDS and AIDS-related discrimination (Volume I, covers 170 cases and Volume II, covers 600 cases, 50 are summarized) reported to the Commission, and includes an analysis of the trends and special circumstances surrounding AIDS discrimination. **AIDS AND PEOPLE OF COLOR: THE DISCRIMINATORY**

**IMPACT** (revised August 1987, 37 pp. report) prepared by the AIDS Discrimination Unit. Discusses the devastating implications of AIDS and AIDS-related discrimination for people of color, for women and children, and for adolescents as well, and explains the need for outreach efforts to these populations. In New York City, 53% of all persons with AIDS are Black or Hispanic; more than 25% of those with AIDS in the United States are Black, 14% are Hispanic. As of September 1987, women constituted 10% of the reported AIDS cases in New York City; 84% of these were women of color. It is projected that by 1991, AIDS will be the largest killer of women of childbearing age in New York City. In New York City today, AIDS is the third leading cause of death for young women from ages 15-19. *Copies are available on request and can be freely duplicated. Keith O'Connor, Director, AIDS Discrimination Unit, Commission on Human Rights, 52 Duane Street, New York, NY 10007, (212) 566-1826.*

**AIDS UPDATE** (monthly *newsletter*). Provides information on AIDS-related issues and seeks input from others to keep it up-to-date. Specifically covers legislation, regulations, decisions, litigation and negotiation strategies, policies and guidelines, community organizing efforts, trends in legal difficulties, and AIDS-

related legal cases. Recent highlights from their newsletter:

Colorado legislation takes effect declaring "HIV infection" a communicable disease and establishes procedures to purportedly control it, including mandatory reportability of "HIV infection."

Georgia adopts regulations requiring HIV antibody testing of all persons convicted of prostitution.

Louisiana enacts AIDS-related legislation, including a law requiring HIV antibody testing in order to obtain a marriage license. Rhode Island Governor vetoes the "AIDS Confidentiality Bill" which would have provided for written informed consent for testing and disclosure of results.

The publishers, Lambda Legal Defense and Education Fund, is in the process of establishing a formal AIDS Clearinghouse in order to make available a wide range of materials useful to attorneys and community activists in their AIDS-related legal, educational and political work. This computerized system will catalog and cross-reference pleadings, briefs, court decisions, legislation and regulations, model proposals, position papers and significant medical information. *Lambda Legal Defense and Education Fund, Inc., 666 Broadway, New York, NY 10012, (212) 995-8085.* Price: *Lambda members, \$30 a year; nonmembers, \$50; institutions, \$75.*

**CAN WE TALK** (1986, Spanish and English *foldover pamphlet*) tells gay men how to reduce their risk of getting AIDS and enjoy sex that is safe—in very explicit, straightforward sex (s)language. Tells what practices are safe, possibly unsafe, and risky—and suggests cutting back on drugs and alcohol. "These risk reduction suggestions are based on guidelines developed by gay-identified health professionals. . . . we are fighting for our lives. We will not deny our sexuality, but we can be sexual in ways that will not put us in significant danger of contracting this life-threatening disease." *Harvey Milk Lesbian & Gay Democratic Club, P.O. Box 14368, San Francisco, CA 94114.*

**COPING WITH AIDS: PSYCHOLOGICAL AND SOCIAL CONSIDERATIONS IN HELPING PEOPLE WITH HTLV-III INFECTION** (1986, 19 pp., *booklet*) written by Bette Runck, Science Communication Branch, Office of Scientific Information, National Institute of Mental Health (NIMH).

Substantial contributions were made by practitioners treating people with HTLV-III infections, NIMH-supported investigators studying the psychological and social aspects of these diseases, other staff of NIMH, the Alcohol, Drug Abuse and Mental Health Administration, and the U.S. Public Health Service, including nursing staff at the National Institutes of Health. This excellent and informative booklet presents rare information on the

mental health aspects of AIDS and "offers guidance to health professionals in their attempts to cope with the challenge of this new disease. It speaks to the needs of both patients and staff. Where noted, the information is based on early results of research on the psychological and social aspects of AIDS. Clinical advice is collated from the experience of physicians, nurses, psychologists, and other health professionals who treated people with AIDS and related conditions during the first four years after the syndrome was identified." *DHHS Publication NO (ADM 85-1432). For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20202.*

#### **HEMOPHILIA INFORMATION**

**EXCHANGE AIDS UPDATE (news bulletin)**, published by the National Resource and Consultation Center for AIDS and HIV Infection of the National Hemophilia Foundation, is extremely informative on AIDS and hemophilia related issues. One can request to be put on this mailing list and/or become a member and receive their publications. Available also are two reports: **AIDS, HTLV-III AND HEMOPHILIA: YOUR QUESTIONS ANSWERED** (April, 1986) which answers 50 often asked questions, and **HEMOPHILIA AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): INTIMACY AND SEXUAL BEHAVIOR** (September, 1985). *Single copies free; bulk rates, \$10 each copy. Peggy Heine, MSW, Program Director, National Resource and Consultation Center for AIDS and HIV Infection, National Hemophilia Foundation, The Soho Bldg., 110 Greene Street, Room 303A, New York, NY 10012, (212) 219-8180.*

**MISSION DISCOVERY REPORT #12: AIDS: A SERIOUS AND SPECIAL OPPORTUNITY FOR MINISTRY** (July, 1987, 12 pp.) is a follow-up to **MISSION DISCOVERY REPORT #9: AIDS: A CHALLENGE TO THE CHURCH** (March, 1987, 8 pp.). The first report was intended to open the subject up for wide discussion in the church. The second report has been written "in response to an expressed desire from both pastors and laity for some assistance in dealing with some of the difficult issues and concerns that evolve in the context of ministry with persons with AIDS and their loved ones," according to James A. Siefkies, Director of Mission Discovery. "Our hope is that this document will prove to be a useful tool for ministry and pastoral care in responding to the AIDS pandemic." Pastor John Backe, hospice chaplain at St. Lukes-Roosevelt hospital, researcher, and writer of the second report, states that "the medical implications are only one aspect of the effect of AIDS. There is also a growing need to consider its emotional, social,

political, theological, and spiritual implications." The report is an attempt to examine how the context for such a ministry of pastoral care is shaped; who is involved; what some of the social and ethical questions are; and to explore some specific responses churches might make when considering their pastoral, educational, and liturgical ministries."

*Mission Discovery, Division of Service and Mission in America, The American Lutheran Church, 422 South Fifth Street, Minneapolis, MN 55415, (612) 330-3100.*

**PREVENTING AIDS THROUGH EDUCATION: INSTRUCTIONAL RESOURCES FOR SCHOOLS** (August 1986; 115 pp., binder format, 8½" x 11" book) by Connor, Johnson, Kerns, McClosky, Thornton, Wandberg and others; a project of the Minnesota Department of Education under contract with the Minnesota Department of Health. Intended for use by educators in presentations about AIDS, but it is *not* a curriculum. It is a set of resources to enable educators to prepare two or three classroom presentations about AIDS and to suggest content and activities that can be integrated into various subject areas, providing options for different developmental levels. It is divided into four parts: about AIDS and AFRAIDS, planning for integration, instructional resources, and AIDS resources. *Minnesota Curriculum Services Center, 3554 White Bear Avenue, White Bear Lake, MN 55110, (612) 770-3943, 800-652-9024.* Price: \$6 each (\$4 in MN) for single and multiple copies, includes p/b.

**REPORT OF THE SURGEON GENERAL'S WORKSHOP ON CHILDREN WITH HIV INFECTION AND THEIR FAMILIES** (April 6-9, 1987, 102 pp., 6" x 9" report, DHHS Publication No. HRS-D-MC 87-1), edited by Dr. Benjamin K. Silverman and Anthony Woddell. As of April 1987 there were 471 reported cases of AIDS among children under 13 years of age and 139 reported cases among adolescents aged 13 to 19 that met the Centers for Disease Control criteria for pediatric AIDS—double the number reported only a year ago. This report, of the Third National Meeting on Pediatric AIDS, focuses on prevention of HIV infection in children and on the difficulties of caring for those children already infected. It summarizes current knowledge and makes recommendations for future directions in the research, prevention, and amelioration of the effects of pediatric AIDS. *U.S. Department of Health & Human Services; Public Health Service, Health Resources and Services Administration Bureau of Health Care Delivery and Assistance, Division of Maternal and Child Health, Rockville, MD 20857.*

**SAFE SEX OR NO SEX: AIDS PREVENTION** (1987, foldover pamphlet) outlines the AIDS problem, risk behavior, and the solution (prevention). This pamphlet has been revised to correct terminology and elaborate on condom use. "We have not called it 'Safer Sex' because we did not want to dilute the message of the title." *Shipping Department, Rocky Mountain Planned Parenthood, 1537 Alton Street, Aurora, CO 80010, (303) 360-0006.* Prepaid prices: pamphlet, \$.50 single copy, \$.12 multiple, \$.09 multiples of 250. p/b.

**SEXUALLY TRANSMITTED DISEASE (STD) (VENEREAL DISEASE)**  
**PREVENTION FOR EVERYONE – A GUIDE: STD PREVENTION & PERSONAL HYGIENE INFORMATION VITAL TO INDIVIDUALS AND COLLECTIVE HEALTH.** (1987, 15th revision, 26 pp., 4" x 9" booklet). "The feelings of shame and guilt traditionally associated with these diseases must be eliminated. After all, such communicable diseases as polio, typhoid, or tuberculosis, not usually thought of as sexually transmitted, may be as easily spread during sex contact as syphilis or gonorrhea. The special threat and dangers posed now by AIDS, the most devastating of the STDs, demand more than ever that we devote our utmost attention to educating the public on the prevention of communicable diseases. . . . It has been well-established that the prevention techniques discussed in this booklet can reduce the STD rate." More than one million copies of this informative booklet, which is also published in Spanish and French, are in use around the world. "We want especially to place the booklets in the hands of teachers, counselors, advisors, and health professionals who can teach this essential information." *The American Foundation for the Prevention of Venereal Disease, Inc., 799 Broadway, Suite 638, New York, NY 10003. Price: \$1 each, \$30 per 100.* ". . . A few booklets are sent to those unable to make a donation."

**WOMEN AND AIDS: A REFERRAL MANUAL FOR WOMEN WITH CONCERN ABOUT AIDS** (October 1985, 2nd ed., 31 pp., 8½" x 11" bound manual) by Patricia A. Madden, sponsored by Project AWARE and the Women's AIDS Network. Provides referrals to San Francisco area organizations for women with questions and concerns about AIDS. Price: \$5. *Women's AIDS Network, c/o San Francisco AIDS Foundation (see below).*

**WOMEN AND AIDS: CLINICAL RESOURCE GUIDE** (1986, approx. 400 pp., 8½" x 11" bound resource guide) Prepared by Women's Health Outreach, a project of the Women's Program of the San Francisco AIDS Foundation. Designed to be used to organize a series of workshops around specific topic areas. Includes sections on transmission/ prevention;

medical overview; infection control; children and teens; psycho-social issues; AID program development; referrals/literature sources. Also includes pamphlets: *AIDS Lifeline: The Best Defense Against AIDS is Information* (1985); *Your Child & AIDS* (in Spanish too, 1986); *Lesbians & AIDS: What's the Connection* (1986); *Straight Talk about Sex and AIDS* (1986), and a catalog of the foundation's educational materials. *San Francisco AIDS Foundation, 333 Valencia, 4th fl., San Francisco, CA 94103. Price: \$40.*

#### **Birth Control**

**BIRTH CONTROL: FACTS . . . FICTION . . . AND ESP: THE CHOICE IS YOURS** (1965, 30 pp., 4" x 5¾" booklet). Covers what it means by ESP (effectiveness, safety and personality) and what it means to you: "The importance of effectiveness to you depends on how important it is for you to avoid pregnancy. . . . how safe are the various methods of birth control? . . . some can be dangerous for certain people but not for others. . . . the type of person you are determines what product will be right for you." Discusses birth control; the need for ESP; those old wives tales (what doesn't work at all, and what hardly works at all); what works and how well; nonprescription methods (abstinence, natural family planning and over-the-counter products); prescription methods (diaphragm, IUD, and the pill); permanent birth control (sterilization, vasectomy and tubal ligation); and products in process of research and development. "At Choices, we emphasize our philosophy of 'patient power,' which means being an informed consumer of medical treatment with the knowledge and information that enables you to make your own decisions about your medical care. . . ." *Choices, Women's Medical Center, Inc., 97-77 Queens Boulevard, Forest Hills, NY 11374, (718) 275-6020. Price: \$2; call for bulk rates.*

**BIRTH CONTROL PAMPHLET SERIES** (1986, fold-over), written by Jane Hiatt. Includes an overview pamphlet (also available in Spanish, Chinese, and Tagalog) that unfolds into a 16" x 17" chart which compares methods of birth control, and eleven method-specific pamphlets: *The Choice to Abstain* (#138), *The Condom* (#139), *The Diaphragm* (#140), *Foam & Vaginal Suppositories* (#141), *The IUD* (#142), *The Birth Control Pill* (#143), *The Contraceptive Sponge* (#144), *Natural Family Planning & Fertility Awareness* (#145), *Tubal Sterilization for Women* (#146), *Vasectomy: Sterilization for Men* (#147). Each of the above pamphlets includes information on the method's effectiveness, how it is used (with illustration), how safe it is, its advantages and disadvantages, and a section on "you can get pregnant if. . ." Also new, and available

are: *What You Should Know About Birth Control...If You Are A Man*, which tells young men how they can be responsible for knowing about and using birth control; and *Your Pelvic Exam*, which tells women of all ages about breast and pelvic exam procedures. *Network Publications*, 1700 Mission Street, P.O. Box 1830, Santa Cruz, CA 95061-1830, (408) 429-9822. Prices: \$25 each; 50/\$11; 200/\$40; 500/\$90; 1000/\$150, plus 15% s/h.

#### *Homophobia*

**BREAKING THE SILENCE, OVERCOMING THE FEAR: HOMOPHOBIA EDUCATION** (1985, 71 pp., *articles*), is a compilation of 16 papers and designs that emerged from a Presbyterian Consultation entitled "Homophobia Education: A Demonstration of Grace," convened at Stony Point, NY, in September 1984. Some of the titles included are: Pastoral Care with Parents and Friends of Lesbians and Gays; Toward Reshaping Our Theology and Ethics Concerning Homosexuality; Homophobia: A Cultural Perspective; and Overcoming Heterosexism: A Challenge to the Church. Single copies are available for \$3.50. Order from: *Presbyterian Church (U.S.A.)*, 475 Riverside Drive, Room 1101, New York, NY 10115.

*Human Sexuality/Sex Education*

**AN ANNOTATED GUIDE TO MEN'S SEXUAL HEALTH RESOURCES** (1986, third edition, 23 pp., 8½" x 11", *guide*) by Douglas E. Beckstein. "This guide was prepared to assist sexuality educators, counselors, librarians, teachers, trainers and others in the selection of the best materials from an ever-increasing number of educational resources available on the topic of men's sexual health. . . . The annotations are the opinions of the authors. All entries were judged after preview based on overall quality. Materials were recommended if they encouraged men to take responsibility for their own personal health and/or take a positive and active role in sharing contraception." Includes information on books, newsletters and journals, audiovisuals, anatomical models, posters, classroom materials, program manuals and reports, related bibliographies and resources, booklets, and "many new films and pamphlets." *Hidden Valley Center For Men*, P.O. Box 392, Soquel, CA 95073, (408) 476-4167. Price: \$5.95.

**FAMILY LIFE EDUCATOR: SELECTED ARTICLES** (1985, 117 pp.), and **FAMILY LIFE EDUCATOR: TEACHING TOOLS** (1985, 77 pp.), are drawn from Volumes I-III of the periodical of the National Family Life Education Network. Selected

Articles contains 29 articles and 37 "What About?" updates on a wide variety of current topics, including eating disorders, reproductive technology, circumcision, and athletically-induced menstrual dysfunction. Forty-five teaching activities are included in *Teaching Tools*, and they cover such subjects as female and male reproductive anatomy, self-esteem, religious perspectives, marriage, and STDs. Each publication available for \$14.95 + 15% p/h. Order from: *Network Publications*, P.O. Box 1830, Santa Cruz, CA 95060-1830.

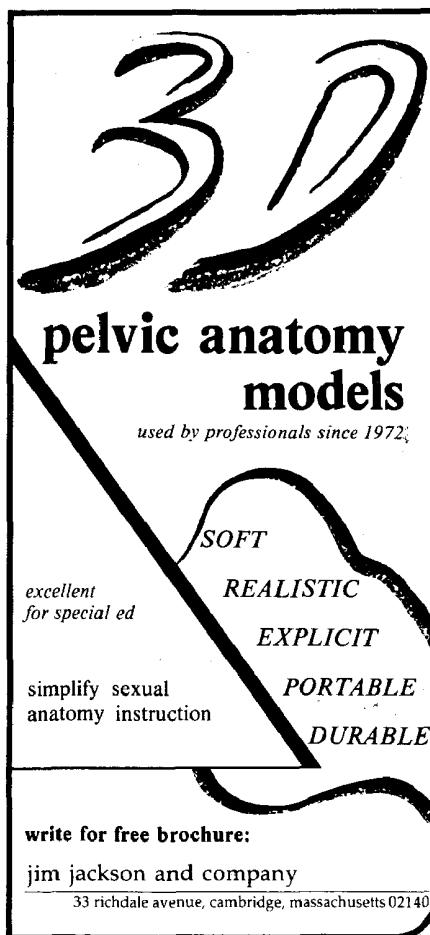
using a lesson plan format. Available for \$35.00 in three-ring binder or \$25.00 without binder (+ 15% p/h) from: *Sun-Rose Associates, Black and White Publishing*, 18 Cogswell Avenue, Cambridge, MA 02140.

**MAKE A LIFE FOR YOURSELF: A BOOKLET FOR TEENS ABOUT LIFE PLANNING** (1986, 12 pp., *booklet*), by Debra Haffner and Sean Casey, is written for early and middle adolescents. It was developed as a companion piece to the *Center for Population Options' Life Planning Curriculum*, which integrates traditional sexuality education with vocational preparation and places delaying parenthood in the context of preparation for the future. *Make A Life For Yourself* can also be distributed on its own in agencies, clinics, churches, and other places frequented by teens. The single copy price is \$1.00, and bulk rates are available. Order from: *Center for Population Options*, 1012 14th Street, NW, Washington, DC 20005.

**PARTNERS IN HEALTH: SEXUALITY: CONTRACEPTIVE AND REPRODUCTIVE HEALTH ISSUES** (1986, 64 pp., *handbook*), by Beverlie Conant Sloane, Mary Taylor, and Madeline Estabrooke Leonard, is a handbook for college students. Topics covered include female and male anatomy and reproductive health, contraception, pregnancy, and STDs. The text is amply illustrated with drawings and photographs. To order, send \$3.95 to: *Charles E. Merrill Co.*, 936 Eastwind Drive, Westerville, OH 43081-3314.

**THE SEX EDUCATION OF SUSIE AND FRED** (1986, 36 pp., *book*), by June Harnest, is a straightforward book for pre-teens about bodily changes during puberty. The changes are described by illustrations of anatomically correct dolls, Susie and Fred (also available for purchase from the author). This resource presents simple explanations of masturbation, dating, petting, intercourse, birth control, child-birth, incest, rape, homosexuality, and STDs. Available for \$5.00 (incl. p/h) from: *Teach-A-Bodies*, 2544 Boyd Street, Fort Worth, TX 76109-1021.

**SEXUALITY...DECISIONS, ATTITUDES, RELATIONSHIPS** (1986, 36 pp., *booklet*), developed by the Education Department of Planned Parenthood Southeastern Pennsylvania, is now available in a revised edition. This popular booklet, written especially for teens and young adults, addresses such topics as values formation, sexual stereotyping, sexual orientation, decision-making, relationships, and peer pressure. Lively line drawings supplement the text. Order for \$2.50 + 15% p/h from: *Planned Parenthood*, 1220 Sansom Street, Philadelphia, PA 19107. Bulk rates available.



**FULLY HUMAN: A PROGRAM IN HUMAN SEXUALITY FOR THE DEVELOPMENTALLY DISABLED** (1985 rev., 167 pp., *curriculum*) is designed for teachers and group leaders working with mildly to moderately retarded children, adolescents, and young adults who may also be emotionally disturbed. It has also been used with severely physically handicapped adolescents who are developmentally delayed and nonverbal. The curriculum is divided into 12 sequential topics, of which the first three—sexual identity, body parts and function, and self and others—are basic to the remainder of the program. Each topic is introduced by instructional goals and content focus and then further broken down into four progressive levels

**SEXUALITY JOURNAL** (first edition, fall 1987, *journal*) published by the Institute for Interdisciplinary Sex Research, Inc. of Hamburg, West Germany which was founded by scientists from different fields in 1979. The Institute's goal is to "expound and communicate a general view of sexuality" and develop appropriate strategies for resolving "problems of present-day significance by collecting historical and current material from various fields. . . . This way, the tradition of an institutionalized investigation of sexology is carried on that was broken in 1933." The new journal will include articles, research projects, essays, bibliographies, a calendar of events, and a review section covering all important popularized and scientific publications related to human sexuality. IFIS has "Europe's most comprehensive library, specializing in sexology, at its disposal" (15,000 books and volumes of journals, autographs, manuscripts, photographs and other documents suitable for illustrating various topics). The library also serves as a data bank for the Institute (DIFIS) and provides selective access to readily retrievable data. Monographs, bibliographies, and research reports on separate topics are also available from IFIS. The Institute also offers therapy and advice. *Institut für interdisziplinäre Sexualforschung, Isestraße 121, D-2000 Hamburg 13, Germany.*

#### *Sexual Abuse/Exploitation*

**IMPACT: SEXUAL EXPLOITATION INTERVENTION FOR THE MEDICAL PROFESSIONAL** (1985, 379 pp., *manual*) brings together expertise in the field of sexual exploitation with existing medical information regarding examination, diagnosis, and treatment. This manual, in looseleaf format, is organized into six skill areas: suspicion, pre-intervention, medical interview, medical examination, medical interface, and treatment. Procedures, checklists, and protocols are given for each, along with forms that can be photocopied. Each of these skill sections has a corresponding knowledge base section that supports and explains it. Available for \$70.00 (+ \$1.50 p/h) from: McClure-Hindman Associates, P.O. Box 208, Durkee, OR 97905.

**RED FLAG GREEN FLAG PEOPLE COLORING BOOK** and the **RED FLAG GREEN FLAG PEOPLE FACILITATOR'S PROGRAM GUIDE** (1987, 30 pp., 31 pp. + appendix, English and Spanish, 8½" x 11" paperback books). Together these books constitute a completely revised ("after a year-and-a-half of research, testing and evaluation") safety program for elementary-aged children. Children learn appropriate kinds of touching with family, friends, and strangers—how to recognize potentially harmful situations, assertive

## In My View. . .

Most of us in sexuality education have, at sometime, encountered *Forum*, the "international journal of human relations," published by Penthouse. Like many colleagues in sexuality, I have found it useful to ask clients and students for a short, gut-level opinion paper on 10 or 20 of the "incredible," but real, letters from the "Forum Advisor" section or from the personal fantasized experiences found in the "Open Forum" section. In exposing the student/client to a wide range of human sexual behaviors, feelings and values surface which can then be discussed and explored with great benefit.

This spring, *Forum* underwent an exciting metamorphosis: Jack Heidenry, the new editor, introduced a new format of four monthly columns which now make up the core of the magazine.

Dr. David A. Shore, founding editor of the *Journal of Social Work and Human Sexuality* and a published professional on the subjects of child sexual abuse, homosexuality and medical sexology, and Charlotte Shore, a registered nurse who presently develops sexuality programs for hospitals, write a column on "Your Sexual Health." Susan Bakos, who has written for such magazines as *New Woman, Savvy*, and *Cosmopolitan*, writes a column answering the question, "What Do Women Want?"; and Susie Bright, editor of the radically erotic lesbian magazine *On Our Backs*, writes a column reviewing erotic video. I write the fourth column, "Future Sex," and, thus far, have dealt with the future of circumcision, artificial wombs, cloning, the effect changes in the Supreme Court may have on pornography, the baby bust, abortion rights, dating contracts, new contraceptives, and research on how child sexual abuse education may be turning our children off to sex.

I think that the new *Forum* deserves a serious look and that creative sex educators, counselors and therapists may find its new format useful in a variety of ways.

—written by **Robert T. Francoeur**, PhD, ACS, Professor of Human Sexuality and Embryology, Fairleigh Dickinson University, New Jersey, author of the textbook *On Becoming a Sexual Person*; author of the books *Utopian Motherhood: New Trends in Human Reproduction* and *Hot and Cool Sex*; and editor of the recently published *Taking Sides: Clashing Views of Controversial Issues in Human Sexuality*.

responses, and who their "helpers" are. Designed primarily to teach personal safety skills to children in a classroom or group setting and to encourage active participation by the children in the learning process. But can also be used by social services, legal, and medical professionals working with children on an individual basis, and by parents by providing a focal point for discussion that is comfortable for both child and adult. The guide takes the facilitator step-by-step through the book. Included are a sample program and announcement for meeting with parents, a consent form, a letter to be sent upon completion of the program, and a resource list of publications and films. The nonprofit Rape and Abuse Crisis Center offers free service to victims of sexual assault, child sexual abuse and domestic violence, and is devoted to research and development of materials to aid in the prevention of sexual abuse. Red

*Flag Green Flag Resources, Rape and Abuse Crisis Center, Box 2984, Fargo, ND 58108, (701) 293-7298 for further information.*

**THE SECRET: A CHILD'S STORY OF SEX ABUSE** (5½" x 8½" paperback booklets), in two versions (one for children four to six, 24 pp.; the other for children seven to ten, 32 pp.). Written by Diane L. McCoy, PhD, a clinical psychologist in private practice and executive director of the Knoxville Center for Human Enrichment; illustrated by Wynne Brown; forward by Suzanne Sgroi, MD, a nationally recognized authority on intervention with child sexual abuse victims and their families. These booklets have been developed as a resource in storybook form, "written in the language of the child," for use with and/or as part of a plan of therapy for child victims of sex abuse who are at different developmental levels. They have been designed so that mental health

professionals, human service workers, nurses, guidance counselors, teachers, district attorneys, parents, physicians, and others, who work with sexually abused children, can help them to express their reactions to their abuse, to the book itself, and to their current life experiences. They are viewed as tools for discovering "what really happened," and as "a first essential step in resolving the emotional trauma caused by their sexual abuse." *Magic Lantern Publications*, 3818 Powers Avenue, Knoxville, Tennessee 37917. Prepaid prices for both are: single copy/\$5.50 plus \$1 s/h; 10/\$49.50 plus \$4 s/h; 50/\$229.50 plus \$10 s/h; 100/\$395 plus \$15 s/h.

**SEXUAL ABUSE! WHAT IS IT?: AN INFORMATIONAL BOOK FOR THE HEARING IMPAIRED** (1986, 71 pp., 8½" x 11" spiral-bound paperback). Written by Karen R. Henkley, PhD, and illustrated by Mary F. Nelson, BFA, for use by hearing impaired adolescents and young adults in an effort to prevent sexual abuse; and as a helpful resource for parents, and tool for educators, counselors, and other professionals to share with the hearing impaired adolescent or young adult. HIHW (Hearing Impaired Health and Wellness) was one of the first programs (1981) to address the problem of sexual abuse among the hearing impaired and is recognized as a national resource in the area of mental health and deafness. *Hearing Impaired Health and Wellness*, St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, MN 55101, (612) 221-2719/3761. Price: \$6.95 each plus 15% s/h.

#### *Teen Pregnancy*

**ARE YOU READY TO MAKE A FOREVER DECISION?: CHILDREN ARE FOREVER** (1986, 33" x 24" poster)—a 4-color teenage pregnancy-prevention poster depicting scenes from a pregnant teenager's life, and her thoughts about what she might be doing instead of what she is doing. Developed especially for middle school and junior high school students. *The Mid-Atlantic Center for Sex Equity*, 5010 Wisconsin Avenue NW, Suite 310, Washington DC 20016, (202) 885-8536. Prices: single copy/\$4; 2-24/\$3.50 each.

**A CHILDREN'S DEFENSE BUDGET, FY 1988: AN ANALYSIS OF OUR NATION'S INVESTMENT IN CHILDREN** (1987, 305 pp., 8½" x 11" book pap.). A tome of information, with sections written by different authors, covers the federal budget process, CDF's legislative agenda, how Congress stands on children, health, family income, homelessness and housing, food assistance, education, youth employment, preventing adolescent pregnancy and

building youth self-sufficiency, abused and neglected children and others with special needs, those in the juvenile justice system, child care, head start, and civil rights.

Includes an appendix with data on children, poverty and federal programs; information about Congress, and additional resources. Price: single copy, \$12.95 plus \$2.50 p/h, 10-19 copies, 10% off total price off plus p/h, 20-99 copies, 20% off plus p/h, 100+ copies, 25% off, plus p/h.

**PREVENTING CHILDREN HAVING CHILDREN: WHAT YOU CAN DO** (1986, 23 pp., 4" x 9" booklet). Gives facts and corrects myths, offers five steps that can be taken to delay too early teen sexual activity and pregnancy, provides an overview of present efforts being made to prevent teen pregnancy and offers a list of related sources. Some interesting facts from this excellent and beautifully written booklet:

*America leads the industrialized nations of the world in the number of teen pregnancies, births and abortions, just counting white teens alone.*

*We are also the only developed country where teen pregnancy rates have been rising in recent years. . . . experts say the difference in pregnancy rates is due, in part, to a more open approach in other countries to sex education and family planning information.*

*Today fewer than one third of all out-of-wedlock pregnancies lead to a marriage. Only 40% of the babies born to unmarried teens were fathered by men in their teens. Three-quarters of the women younger than 25 who are single parents live on less than \$9000 a year.*

*The younger a student is when she becomes a mother, the less likely it is that she will complete her education.*

*Teen mothers now have the right to stay in school, but few have the financial ability and support systems to solve the child care and transportation problems that keep them from attending.*

CDF has established an Adolescent Pregnancy Prevention Clearinghouse which issues bimonthly reports on all aspects of teen pregnancy. Price: \$1 each for single and multiple copies, includes p/h. Children's Defense Fund, 122 C. Street NW, Washington, DC 20001, (202) 628-8787.

**ESTIMATES OF PUBLIC COSTS FOR TEENAGE CHILDBEARING: A REVIEW OF RECENT STUDIES AND ESTIMATES OF 1985 PUBLIC COSTS** (September, 1986, revised and expanded spiral-bound report) by Martha R. Burt, PhD. This report highlights the impact of adolescent births on the nation's budget. The report states that: "All families begun by teen first births in 1985 will cost the U.S. \$5.2 billion over the next 20 years, in 1985 dollars" and that "programs aimed at preventing adolescent pregnancies have the potential to cut these

costs dramatically." However, if we reduce prevention programs we "will in effect increase the number of families which must rely on public assistance." CPO advocates improved access to sexuality information and family planning services for all adolescents and states, in this report, that teenagers must have direct and accurate information about sexuality, including support to delay sexual activity as well as access to convenient, confidential, and affordable family planning, counseling, and medical services. They must perceive real options for their futures in order to be motivated to avoid premature childbearing, and they must have access to both quality education and vocational opportunities. Price: \$8 plus 15% p/h (bulk rates below). **TEENAGE CHILDBEARING: HOW MUCH DOES IT COST?: A GUIDE TO DETERMINING THE LOCAL COSTS OF TEENAGE CHILDBEARING** (October, 1986, 87 pp. handbook in sturdy binder) by Martha Burt, PhD, and Deborah Hafner, MPH. National estimates indicate that in 1985, the United States spent \$16.65 billion on families that were begun when the mother was a teenager. This practical guide to conducting has been produced so that similar estimates can be conducted on a local level by teen pregnancy task forces, service providers, community groups, or government agencies to determine how much a city, country or state spends on teenage childbearing in a given year.

Successfully pilot-tested in three communities, the handbook now includes indepth instructions, helpful tables, and large workable charts, separate worksheets, and a section on publicizing the results of the study. A LOTUS 1-2-3 software program has been developed to accompany the handbook which eliminates approximately 40 hours of manual calculations. Prepaid prices: handbook alone, \$25 + p/h, with computer software, \$90 + p/h. Publications, Center for Population Options, 1012 14th Street, Suite 1200, Washington, DC 20005, (202) 347-5700. Prepaid prices: handbook alone, \$25 + p/h, with computer software, \$90 + p/h. Bulk rate prices for all CPO publications: 10-19, 10% discount, 20+, 15% discount.

**WORKING WITH TEENAGE FATHERS: A HANDBOOK FOR PROGRAM DEVELOPMENT** (1986, 63 pp. handbook), by Joelle Sander, grew out of the Teen Father Collaboration, a two-year research and demonstration project serving 400 young men in eight sites nationwide. The manual is divided into seven chapters, including start-up issues, effective strategies for reaching teenage fathers, essential services, staff development, and five model programs. Order for \$10.00 (incl. p/h) from: Joelle Sander, Bank Street College of Education, 610 West 112th Street, New York, NY 10025.