INDEPENDENT SCHOOL HEALTH ASSOCIATION

Winter 1988–89 Newsletter

Changing Times, Changing Needs:

Ann Welbourne–Moglia Discusses Coping with Adolescent Sexuality Today

Lin Bredenfoerder reports on the Spring Conference Keynote Address

In spite of the fact that the wind blew and snow fell at this spring's ISHA conference, the meeting went forward and the time of year allowed Ann Welbourne-Moglia to open her keynote address with a timely observation about sexuality, comparing the rising sap in the trees and the stormy weather outdoors to the rising and raging hormones of adolescence. Dr. Welbourne-Moglia raised two questions in regard to this hormonal tempest. One, how have sexuality and teenage life changed since ISHA members were young? Second, how can adults help young people cope with their sexuality and changing needs in today's world? As a means for answering these questions, Dr. Welbourne-Moglia challenged her listeners to remember what it was like when they were growing up and to compare then with now.

Pregnancy in High School

"When you were in high school, how many girls became pregnant and what happened to them?" Dr. Welbourne-Moglia's question prompted members to remember those bygone days when pregnancy was greeted with shameful accusation and silence. The figures on adolescent sexual activity and pregnancy today mean that we can no longer be silent or deal with these problems with a quiet wish that they "disappear." More than 1 million teenagers become pregnant in the United States each year; 70% of today's teenage girls and 80% of teenage boys will experience sexual intercourse at least once before they graduate from high school; more than 50% of young people who are sexually active will have sex without contraception; 30% of all teenagers having sex will never use contraception; most teenagers will not use protection until they have already been sexually active for one year. Perhaps worse are the facts concerning the future of those girls who do get pregnant and drop out of school: the largest employer of high school dropouts is McDonalds and girls who get pregnant and then leave school are unable to get good jobs. Pregnant high school girls who drop out have little chance of ever earning an income above poverty level.

Sexual Abuse

Like teenage pregnancy, rape and sexual molestation were also met with silence in years past. Today these issues flood the news. In part because people—both criminals and victims—

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Ann Welbourne-Moglia, RN, PhD, Former Executive Director, Sex Information and Education Council of the U.S. (SIECUS); clinical psychologist in private practice

Workshop: Delivering Sexual Health Care in the Schools
Gloria Holbrook, RN, CNP, Phillips Andover Health Services
Felicity Pool, RN, MS, Health Educator, Northfield Mount Hermon
Madeline Zelonis, RNC, BSN, Director of Nursing, Choate Rosemary Hall

Workshop: Sexual Orientation: The Heterosexual–Homosexual Continuum
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Workshop: Addressing Sexual Concerns of Adolescents
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have spoken up about these issues, it is now possible to get an idea of how widespread rape and sexual abuse are in today's society. We now know that one in four of today's female teenagers will experience some form of molestation or sexual abuse before she reaches her eighteenth birthday.

Disease

As Dr. Welbourne-Moglia recounted, and as many of her listeners recollected, most adults today were out of high school before they knew what venereal disease was. The predominant feeling in the "old days" was that "nice people" didn't get sexually transmitted diseases. Presently, hardly a week goes by without a major story about AIDS reaching news readers and watchers and, several years ago, herpes made the cover of *TIME* magazine. The facts today are that one in seven adolescents has a sexually transmitted disease and that this rate has been doubling annually since 1980. Today, 50% of the population with an STD is under the age of 25. In addition to herpes and AIDS, another STD, genital warts, has been on the rise, yet has received little attention in the press. The occurrence rate of genital warts has skyrocketed 46% in the past five years. The incubation period for genital warts is long, possibly up to 40 years, and there is a strong association between them and cervical cancer. Further, they are closely associated with smoking and the use of birth control pills.

Drugs

Due to the dramatic increase in drug abuse in the last few years, Dr. Welbourne-Moglia pointed out that it would be virtually impossible for any adult today to have come into contact with the same percentage of substance abusers as the number which today's youth encounter. A study in New York performed a few years ago showed that 31% of its school-age children had tried illegal drugs before the seventh grade. In light of these facts, Dr. Welbourne-Moglia emphasized that telling youngsters to "just say NO!" does not diminish the drug problem; children must be taught *how* to say no if they are going to maintain a healthy distance between themselves and drugs and drug users.

Homosexuality

Dr. Welbourne-Moglia recalled with the audience those "special" days of the week in their high schools when they didn't dare wear a certain color—the implication being that if they did they were "queers" or "fags"—yet few knew what these words meant. Today, as a consequence of, on the positive side, the gay rights movement and, on the negative, the AIDS epidemic, homosexuality is openly discussed and discourse about "sexual identity" has become a significant part of sexuality education. Today's adolescents face not only questions of when and with whom to have sex, they also face difficult issues of sexual preference and practice.

Educating Today's Adolescents

Dr. Welbourne-Moglia's comparisons of today and the "old days" illuminated in what a vastly different, more complex and dangerous world today's teenagers exist. Her discussion also demonstrated that, regardless of these major differences, certain fundamentals of adolescence remain constant. Adolescents still need adult support, and adults still have a responsibility to help adolescents through what are sometimes difficult and painful situations.

Adolescence is a time of questioning, a time when the world seems at once delightfully up for grabs and painfully ambiguous. Individually and as a group, psychologically and socially, adolescents present us with a multitude of questions needing to be answered: Who am I? Who's in charge here? Who are you? What's our relationship? What's my role in life? Who are my friends? How do I relate to my family? On what basis do I form my values? To answer these questions, adolescents need good self-esteem and positive role models. The challenge to adults is to be these role models, to teach adolescents about life and to help them integrate their learning—in short, to help young people be healthy people. Part of this health is a positive sexuality and part of our responsibility is providing adequate, effective sexuality education for adolescents.

To teach adolescents about sexuality, teachers and leaders must understand that sexuality is a part of personality, not just sexual acts or conduct. It is more than fast cars, tight blue jeans, perfume and makeup. Teachers and leaders need to be aware that sexuality starts at birth and lasts until death, and they must also bear in mind the sources for adolescent knowledge—and adolescent mythology—concerning sex.

Sources of Knowledge

As has been true for decades, the primary source of information about sex for today's adolescents remains same-sex friends. Television and magazines also function as sources of information for teens, but it should be noted that television programs rarely confront the decision to have intercourse, much less deal directly with using birth control or methods of contraception. Anatomy and growth & development courses teach students the biological specifics of sexuality. Family and religious institutions try to do their part in helping youngsters develop their sexual values. In spite of this input, however, instances of teenage pregnancy remain alarmingly high and the depth of knowledge teenagers have about sexuality remains dangerously shallow. Facts like these only serve to highlight the need in our schools for education and counseling programs aimed specifically at developing students' awareness of their own sexuality and of the sexual issues which may affect them.

Measuring Program Effectiveness

In the past few years, significant strides have been made toward bringing effective sex education into the nation's high schools. A recent Harris poll showed that 85% of parents favor sex education programs. New Jersey, Maryland and the District of Columbia have mandated sex education. Some states have created local task forces to set up programs for their teenagers. Still, sex education has yet to close the gap between negative statistics and positive solutions. Currently, sex education programs vary from school to school, with fewer than 50% offering comprehensive programs and a great many presenting categorically remedial material.

How effective can a sexuality program be? The most effective and innovative programs combine health education, sex education and "life-planning" in what is referred to as an "integrated" approach. The integrated approach works well to equip adolescents with skills they can use when coping with the pressure to engage

in sexual activity, helps them to understand and develop self-esteem and directly and positively impacts the age of onset of sexual activity and pregnancy and dropout rates. Other methods which sex educators have found to contribute to program effectiveness include parent participation and peer counseling. Involving parents increases program comprehensiveness and assures that further education will take place at home. Peer counseling encourages adolescents to share with people their own age who have similar concerns. Peer counseling works best when the students have a say in what and how a program will be implemented. The establishment of a school clinic operated in conjunction with a school's educational program appears to have the most measurable impact on teen pregnancy. However, many schools have found this alternative too controversial to implement.

Dr. Welbourne-Moglia pointed out that the question, "How effective are sexuality programs?" is largely unanswerable and that it is more realistic to focus on what the programs accomplish in terms of education than on what they accomplish in terms of statistics or numbers. Sexuality programs *do not*, contrary to popular misconception, increase or invite rampant sexual acitivity. They *do* encourage adolescents to look at their sexual values and come to terms with some of the myriad changes, hormonal and otherwise, which affect their lives. The good news about adolescent sexuality education today is that sexuality programs are becoming more available, that there *are* people who care and who want to help adolescents grow into informed, skilled and healthy young adults. This is particularly true of those teachers, counselors, health care staff and others working in independent schools.

Don't Forget:

Include ISHA in Your Upcoming Budget

ISHA dues for the 1989–1990 school year will be due August 31, 1989. The fees remain the same as they have for the past two years:

Schools with over 500 students
$200
Schools with under 500 students
$100
Individual Membership
$25

Delivering Sexual Health Care in Schools

Workshop Report by Gloria Holbrook

Gloria Holbrook, RN, CNP, school nurse practitioner at Phillips Andover Health Services, Felicity Pool, RN, MS, health educator at Northfield Mount Hermon, and Madeline Zelonis, RNC, BSN, GYN, clinician and director of nursing at Choate Rosemary Hall, were the presenters of this informative workshop outlining the development and delivery of effective reproductive health care. Phillips Andover, where Ms. Holbrook is school nurse practitioner, has had such a program since 1979, when the school became coed and the necessity of a program became apparent. Today, Andover's program is widely used and has become an integral part of the school's health services.

As an aid to schools seeking to develop similar programs or to improve those already in existence, the presenters offered workshop attendees a copy of the Phillips Andover philosophy for reproductive health care at school. The programs in use at Choate Rosemary Hall and Northfield Mount Hermon share philosophies similar to Andover's. The Andover philosophy stresses four points:

1. To create a climate within the institution which encourages students to seek understanding and information about sexuality.

2. To support and encourage the development of lifelong responsibility toward sexual activity on the part of all adolescents.

3. To support and encourage an approach to adolescent reproductive health care as part of total care that promotes health and prevents disease.

4. To provide contraceptive education, counseling and high quality medical services to all male and female adolescents desiring such service. Parental involvement is encouraged but not required.

In addition to outlining a clear philosophy, the presenters offered some practical instructions for the development and delivery of reproductive health care. Felicity Pool pointed out that counseling is an important part of health care quite apart from birth control and that sexual health care counseling need not always be connected with issues of contraception. All three presenters stressed that strong support from a school physician is essential in implementing a program, as well as support from the school board of trustees. In addition, they caution program developers to consult with school lawyers to clarify laws regarding minors and birth control, pregnancy and confidentiality.

Once a reproductive health care program is implemented, program directors should pay particular attention to providing students with confidentiality, to letting students know that services are available and to understanding student needs for counseling and explanation. Outreach programs, in which health providers visit dormitories, go to health classes and talk to health counselors, are effective ways to inform students of program availability, as well as to provide students with a forum to discuss sexual issues. Keeping an open, flexible schedule will encourage students not to be shy about seeking services and a thorough explanation of pelvic exams and any testing will guarantee that there are no surprises in store for the student, thus increasing his or her confidence in the health program generally.

All health care providers should remember that issues about sexuality involve males and females equally. Every effort should be made to make sure that both sexes receive and seek services. It may be wise to remind students, faculty, parents and others that studies have shown that education about sexuality does not increase sexual activity. The purpose of a reproductive health care program is to create the opportunity for adolescents to learn life-long health habits concerning reproductive health care and responsibility.

Sexual Orientation: The Heterosexual–Homosexual Continuum

Summary of a Workshop Presentation by Ann Welbourne-Moglia, RN, PhD

by Char Davidson, Codirector, Counseling Services, Choate Rosemary Hall and Former ISHA President

As part of their sexual development, young children engage in a fair amount of same sex play, touching and exploring themselves and one another as a means for learning about their identity. By the age of three or four a child knows whether he or she is a boy or girl. By four or five, the same child develops a sense of what are considered culturally appropriate male/female behaviors. Children this young can describe, based on sex, what adult men and women do in terms of work and other activities.

For the adolescent, sexual fantasies, erotic feelings or sexual experiences with a same sex friend may generate a great deal of anxiety. There is an assumption that these feelings and behavior directly indicate homosexual orientation. The same assumption holds true for some adults, but for the adolescent struggling with self-acceptance this can be especially anxiety-provoking. Yet same sex friendships and experiences and adolescent "crushes"—whether on same sex or opposite sex teachers, older students or rock stars—are normative in early adolescence; they form part of a young person's fantasy life and are a kind of mental practicing, as well as an outlet for sexual feelings.

The question of how a person's sexual orientation evolves, as opposed to knowledge of their sex, continues to challenge human sexuality researchers. In studies of sexual orientation two predominant theories have emerged, biological/genetic and psychosocial. Sexuality researcher Alan Bell expresses the biological/genetic theory in the following terms, "A boy or girl is [genetically] predisposed to be homosexual or heterosexual…during childhood and by adolescence this basic sexual orientation begins to become evident." Bell and his colleagues define sexuality as "a pattern of feelings and reactions within the child that cannot be traced back to a single social or psychological root." No conclusive evidence has been found for genetic/biological theories of sexual orientation, and this is part of the reason that there has been greater acceptance among sexuality researchers for psychosocial theories.

Psychosocial theories of sexuality emphasize an individual's interaction with his or her environment, assert that a person learns sexual orientation over time and hold that sexual orientation is shaped by a subtle but powerful interplay between individual psychology and erotic preference as formed by interpersonal experiences. Researchers using a psychosocial approach have been able to systematically study and reject many common myths about homosexuality. These include the myths that an individual's relationship to his or her parents may lead to homosexuality, that same sex play or experiences with other children or adolescents will foster a homosexual orientation, or that in simply *knowing* a homosexual—in the role of teacher, coach or other significant adult—one will become homosexual.

The so-called "continuum" of sexual orientation is based upon research performed by pioneering sexuality researcher, Kinsey. In a report on his research published in 1948, Kinsey detailed a range of human sexual expression from the primarily heterosexual to the primarily homosexual with degrees of bisexuality operating between the two. Kinsey's work debunked the belief that humans were categorically straight or gay and revealed that men and women typically had a variety of types and kinds of sexual experiences over a lifetime. Kinsey found most people in a given population to be predominantly heterosexual and projected 2% of the female population and 4% of the male population to be predominantly homosexual.

Since Kinsey's research, the incidence of homosexuality has risen. Today's sexual researchers find approximately 10% of the American population—six million people—homosexual. Sexual researchers attribute this increase to a variety of factors, such as greater tolerance for sexual expression and work undertaken by gays and lesbians to protect their civil rights and disclose myths perpetuating homophobia.

Included in Dr. Welbourne-Moglia's presentation were the following working definitions which health educators and others may find useful for opening discussion of the heterosexual–homosexual continuum:

Sex: The biological reality of being genetically and anatomically male or female.
Gender: The connotations given in a particular society about being masculine or feminine.
Gender identity: How one psychologically perceives oneself as either being masculine or feminine.
Gender role or sex role: A collection of attitudes and behaviors that are considered normal and appropriate in a specific culture for a given sex.
Sexual orientation: Sexual attraction to one's own sex or the other sex; whom or what a person eroticizes; sexual attitudes and preferences; the behaviors we engage in and the lifestyle we adopt.

Request for Protocols

We've had a request for help from a nurse at a member school who is looking for standing orders and protocols for use in her infirmary. If you have either of these and would be willing to allow her or others to use them—a number of people have asked for this information over the years—please contact the ISHA office c/o Berkshire School, Sheffield, MA 01257 or phone us at (413) 229-8511 ext. 44. Any information you can share will be helpful to us as we're trying to build a list of resources for our members. Information concerning standing orders or protocols using a textbook would also be much appreciated.

Addressing Sexual Concerns of Adolescents: A Human Sexuality Program

Workshop Report by Jane Howe, Dean of Students, Loomis Chaffee School

Ellie Griffin, director of health services at Milton Academy and presenter, along with Jack Stermer, also from Milton, opened their workshop with a broad definition of a program in human sexuality. Ms. Griffin pointed out that an effective program must not be purely informational, it must meet and respond to adolescent needs. Providers must give thought to the major concerns of young people in regard to their sexuality and must effectively integrate material related to those concerns into their programs.

The rapid physical and emotional development that typifies adolescence introduces the young person to many new and strange feelings for the first time. Adolescents need to learn that their feelings, sexual urges and body growth are both normal and understandable. An effective program must teach participants the skills for coping with these feelings, and emphasize that coping is possible. A sexuality program should additionally encourage students to explore their sexual identity and to understand the homosexual–heterosexual continuum. Time should be given to discussing gender roles, the differences (real and imagined) between the sexes and confusing signals that students may receive from the media and others about what it means to be either masculine or feminine. Providing students with opportunities to discuss individual feelings about sexual issues, identity and lifestyle is one means providers have to better enable students to accomplish understanding and growth in these areas.

At a time when the adolescent's self is undergoing tremendous changes, achieving adequate self-esteem can be enormously difficult, the more so in the context of an independent school with much spoken and unspoken emphasis on high academic standards and college admission. Ms. Griffin offered a list of questions which might be used for exploration into an adolescent's self-esteem, including: "Where does self-esteem come from? From achievements? From within?" and "What makes a person of value to himself/herself or to another?" Program leaders may wish to discuss these questions with students as a means for helping them understand the nature of their feelings about themselves.

To deal with questions and issues surrounding sexual activity specifically, program coordinators need to be aware of their students' desire to talk, particularly about the decision to be sexually active or not. Coordinators need to share with their students the particulars of sexuality, but they must also emphasize that the first step in any sexual act should be one of words, that is thoughtful, caring discussion with one's partner. Many adolescents do not know what it feels like to "be in love" and may ask for a definition. A quote from Eleanor Hamilton's book *Sex with Love* may be worthy of exploration: "The well-being of the other is essential to one's own well-being." It is also of crucial importance to point out to adolescents that while the need for a caring touch is virtually universal, this need can lead to uncaring sexual situations. Enabling students to recognize and understand what is and is not sexual abuse is yet another responsibility of a healthy program in sexuality.

The specifics of the human sexuality program at Milton were outlined by Jack Stermer, Milton's director of health education. The program Mr. Stermer described is voluntary, offered to the upper three grades and meets once a week for 90 minutes, in the evening, for nine weeks. Discussion groups consist of 12 students, equally divided between boys and girls, and two adults, one male and one female. Parents are invited to attend, but because the program is voluntary, students do not need to obtain parental permission in order to participate.

Mr. Stermer and Ms. Griffin handed out several helpful resources at the end of their workshop. Among these were a week-by-week description of the program in use at Milton, an evaluation form for assessing sexuality programs, a list of questions for school personnel to consider when developing their own program and samples of questions asked by students involved in the program at Milton.

Teenagers' Concerns about Sex Addressed in New Book by Children's Hospital

In 1984, thousands of teenagers representing a wide range of ages, socioeconomic groups, races and geographic areas were given the chance to ask anything they wanted about sex. In response, the teenagers shared thoughts, feelings, concerns and uncertainties and asked questions, both honest and sincere; specific and broad; simple and complex; mild and hard-hitting. Members of Children's Health Information Department at Boston Children's Hospital collected these questions, read them carefully and organized them into categories. Thus began a new book from the Children's Hospital, *What Teenagers Want to Know about Sex: Questions and Answers* with Robert P. Masland Jr., MD, chief of the Division of Adolescent/Young Adult Medicine.

Dr. Masland says that letting the teenagers' questions tell the story brings a special "freshness and honesty" to the book that is missing from most other books about sex and human sexuality. Written in a candid, nonjudgmental style, the book remains sensitive to the complex needs and feelings of teenagers as well as their parents. The goal is not to lecture or preach, but to inform and educate so teenagers will have the information necessary to make decisions that are right for them.

Divided into 19 chapters, *What Teenagers Want to Know about Sex: Questions and Answers* includes such general topics as "Thoughts, Feelings, and Concerns of Teenagers" and "What is Sexuality?" as well as "AIDS," "Menstruation," and "Sexual Identity." The book is published by Little, Brown and Company and will be available in bookstores by early May. The hardcover edition sells for $16.95; a paperback edition is expected to be published in about a year.

Coping with Child Abuse and Sexual Harassment

Child abuse and sexual harassment incidents, whether at home or at school, can be the most difficult tasks for health care providers, faculty members, administrators and parents to confront and deal with. As caretakers and providers, adults in contact with children who have been abused—physically, sexually or emotionally—have a responsibility to the child to handle such incidents effectively. They also have responsibilities toward parents and colleagues to investigate thoroughly, to explain facts clearly and to have on hand as much information as possible, both in regard to a specific incident and in regard to its psychological, legal and other implications. No one wishes to anticipate an incident of abuse, but the duty of schools and school officials to be prepared to deal with such an incident, should it arise, cannot be ignored.

In October 1987, Headmaster Peter Gunness of Buckingham Browne & Nichols School appointed a task force including faculty, parents and school officials, as well as the school's director of studies, the upper school dean of studies and the lower school director, to develop a program for BB&N on child abuse and sexual harassment. The goals of the task force were twofold: 1) to increase awareness of issues concerning child abuse and sexual harassment and 2) to explore appropriate ways for the school and for individuals within the school to respond to child abuse and sexual harassment. Members of the task force combined the results of their studies in an outline of general principles and policies which education and health care providers may find useful for adaptation to their own needs for handling these difficult issues.

It should be stressed that this outline is the fruit of intensive studies and that in completing it task force members solicited input and facts from legal, psychological and other experts in the fields of child abuse and sexual harassment. A school that wishes to implement similar policies, or to adapt these for their own use, should likewise solicit counsel from experts. Legal procedures differ from state to state, while informational hierarchies will differ from school to school. For further information in these areas, contact your school lawyer and local health and legal officials.

BB&N has included these guidelines in a comprehensive report submitted to school faculty, school officials and families of BB&N students. The report, "Report of the Task Force on Child Abuse and Sexual Harassment," also details specific definitions of and procedures for dealing with child abuse and sexual harassment and includes comprehensive sections on crisis management as well as proposed information supplements for parents. For additional information or to obtain a copy of the report in its entirety, contact:

Mary-Alice Brennan-Crosby
Buckingham Browne &
Nichols School
Gerry's Landing Road
Cambridge, MA 02138
(617) 547-6100

Buckingham Browne & Nichols School Policies Regarding Child Abuse and Sexual Harassment

General Principles and Policies

1. Providing a safe and secure environment for all our students is a primary goal of the school.

2. No set of policies and procedures can or should replace trust, goodwill and the judgments of reasonable people.

3. BB&N students, parents, faculty and staff should be sensitive to and educated about the nature of child abuse and sexual harassment.

4. BB&N students should be protected from any form of child abuse. BB&N students, faculty and staff should be protected from any form of sexual harassment.

5. All BB&N students, faculty and staff are expected to be able to recognize signs and symptoms of child abuse and sexual harassment and to take responsibility for dealing with any such incidents either on campus or at any off-campus school-sponsored function. Parents are also expected to notify the school (see item 6) if they have reasonable cause to believe that a BB&N student is a victim of child abuse or sexual harassment.

6. Formal complaints regarding possible child abuse or sexual harassment may be addressed directly to the Headmaster or to the Upper, Middle or Lower School Directors, who will then forward such complaints to the Headmaster. If the Headmaster is unavailable, or has to disqualify himself, he will designate one or more of the Assistant Heads to assume his responsibilities.

7. Any complaint made in writing will be investigated, resolved and kept permanently in a confidential file that can be reviewed by the Headmaster or those authorized by him.

8. The Headmaster will be expected to review all child abuse and formal sexual harassment reports on a periodic basis to determine if there is any pattern of child abuse and sexual harassment involving an accused individual. Based on this review, the Headmaster will determine whether or not any further action is necessary.

9. It is understood that the school's review and investigation of instances of child abuse does not supplant its legal mandate to notify the Department of Social Services (DSS). Where appropriate, the school will work collaboratively with the DSS and the District Attorney's office, and the school's investigation of child abuse incidents may be guided by the advice from these agencies.

10. The Directors of the Upper, Middle and Lower Schools, after consultation with the faculty, will appoint and announce one or two male and female faculty members on each campus to deal with concerns regarding child abuse and sexual harassment. These designated faculty members will meet regularly on each campus. They will attend workshops with outside consultants for training and acquisition of skills.

Sexual Assault: Yale Produces a Handbook

Yale University has responded to the nationwide rise in sexual assault on college campuses with the publication of its handbook, *Sexual Assault and the Yale Student*. The 12-page handbook covers such important topics as how to anticipate and prevent possible sexual assault and how to cope and proceed in the aftermath of an attack. Points stressed are the importance of giving clear signals to dates and friends and the importance, if an assault does occur, of seeking immediate medical and psychological attention. Two other areas covered are the sexual assault of males and guidelines for friends of sexual assault victims.

The bibliography included at the end of the booklet lists the following publications which may be of interest in developing a handbook or in improving one already in use:

Brownmiller, Susan, *Against our Will*, [New York: Simon and Schuster] 1975.

Burgess, Ann Wolbert and Holstrom, Lynda Lytle, *Rape: Victims of Crisis*, [Bowie, Md.: Robert J. Brady Co.] 1975.

Connell and Wilson, *Rape: First Sourcebook for Women*, [New York: New American Library] 1974.

Horos, Carol V., *Rape*, [New Canaan, Conn.: Tobey Publishing Co.] 1974.

Hughes, Jean O'Gorman and Sandler, Bernice R., *"Friends" Raping Friends, The Project on the Status and Education of Women*, [Association of American Colleges] 1987.

Medea, Andra and Thompson, Kathleen, *Against Rape*, [New York: Farrar, Straus and Giroux [Noonday Press]] 1974.

Parrot, Andrea and Lynk, Robin, "Acquaintance Rape in a College Population" available from Andrea Parrot, Ph.D. N132 MVR Hall, Cornell University, Ithaca, New York 14853.

For copies of the Yale handbook, write to:

Dean Patricia Pierce
Yale College Dean's Office
1604-A Yale Station
New Haven, CT 06520

and enclose a self-addressed, stamped (45 cents postage) #10 envelope.

Request for back issues of the ISHA Newsletter:

Fall 1982
Fall 1984
Fall 1985

We need copies of these *ISHA Newsletters* to complete our archives. If you have extras, please send them to:

ISHA
c/o Berkshire School
Sheffield, MA 01257

SIECUS Reports

Two recent issues of the *SIECUS Report* address sexuality issues of great concern to independent school health educators: school AIDS education and adolescent sexuality and abstinence. The first of these (*SIECUS Report*, Vol. 15 No. 6, July/August 1987) details the variety of approaches educators have taken and may take to teach adolescents about acquired immune deficiency syndrome, including topics such as the politics of AIDS education, determining curriculum for AIDS education and identifying the accuracy of AIDS information and educational materials. Also included in the issue is an extensive bibliography of sourcebooks and educational and media material for use in educating adolescents and others about AIDS.

The September/October 1988 issue (*SIECUS Report*, Vol. 17 No. 1) addresses problems related to introducing abstinence as an alternative for adolescent sexual practice. Health educator Lynn Peterson's article, "The Issue—and Controversy—Surrounding Adolescent Sexuality and Abstinence," stresses the importance of abstinence as an approach to healthy mature sexuality and the danger that educators may adopt a negative, moralistic approach in educating adolescents about abstinence. As an example of the latter, Ms. Peterson cites curricula which warn teenagers against having sex before marriage and assert that having premarital sexual relationships can permanently damage their capacity to experience true love as adults. "Although we do not agree on the definition of positive teenage sexuality," Ms. Peterson notes of herself and her colleagues,"we do agree that young teenagers should ideally not have sexual intercourse."

In support of her own approach, Ms. Peterson includes in her article a list of criteria by which some adults might condone an adolescent sexual relationship:

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

"Those that believe that teens need to reach a certain level of full and positive sexual maturity before engaging in sexual intercourse would probably agree that this list is supportive of that goal," comments Ms. Peterson.

For copies of either *SIECUS Report* issue, or for information on additional issues contact:

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A Note from ISHA President, Lin Bredenfoerder

Over the years I've watched the ISHA membership expand across the country, attended conferences that have moved me to action when I returned to Berkshire and seen the *ISHA Newsletter* come into existence and grow from four basic pages to 12 pages with photos, artwork and charts. It's been an exciting 10 years. My involvement with ISHA has changed from conference attendee to ISHA Council member to my current position as the new ISHA president. I'm happy to be here and look forward to my term as your president.

I've taken on the job as ISHA president because I believe in the support that ISHA can provide for its members. One of the major ways that ISHA supports you is through the newsletter. The newsletter is here to serve you. Do you have a problem that you'd like to have help solving? Maybe you'd like to know what policy other schools have regarding participation in sports by a student who has a chronic health problem or is missing one of a pair of organs? Write a letter including your question for us to include in the next newsletter. Do you know of a good educational program? If so, write us a letter or write a review that can be included in the next newsletter.

Reviews, articles and letters for the newsletter don't have to be long. This is your forum and we'd like to have more of your input. The sharing process is invaluable to those ISHA members who live too far away to attend our conferences. ISHA has members in Switzerland, California, Colorado and Michigan—plus all of the northeastern states and as far south as Virginia. People from distant schools faithfully send in their membership fees and count on our newsletter as a means of communication with people in other independent schools. So don't be shy, get your money's worth by participating in ISHA's newsletter and if you can get to the spring and fall conferences, come by and introduce yourself. ISHA will be what we make it.

The ISHA Council meets three times a year to plan conferences and the content of newsletters and other ISHA publications. On hand at the November 11, 1988 meeting at Mt. Holyoke were (From left): Ellie Mercer, Suffield Academy (CT); Blair Jenkins, Dana Hall (MA); Jane Howe, Loomis Chaffee School (CT); Dick McKelvey, Deerfield Academy (MA); David Panek, St. Paul's School (NH); Bud Gouveia, Avon Old Farms (CT); Coleen Dolinish, Berkshire School (MA); and Lin Bredenfoerder, ISHA president, Berkshire School (MA). Carol Cheney, ISHA publications editor, was behind the camera.

Coming Up

The ISHA Spring 1989 Conference:
Current Issues in Adolescent Sports Medicine

April 7, 1989
Avon Old Farms School
Avon, CT

Keynote Address: Adolescent Sports Medicine
Arthur Pappas, MD

Workshop: Smokeless Tobacco
Dr. Leslie Cutler

Workshop: Strength Training and Steroids
Yves Labissiere

Workshop: Sports Related Problems of the Female Athlete
Mary Ann Laska

Workshop: Evaluation of the Injured Knee
Steve Bessette

Sports Nutrition: Separating Fact from Myth

by Bud Gouveia, ISHA Chairperson for Athletic Trainers, Athletic Trainer, Avon Old Farms School (CT)

Because of the susceptibility of young athletes to the advice of their peers and to the "training tips" featured in some magazines and sports publications, many trainers and coaches find it difficult to convince their athletes that there are no easy substitutes—no "miracle diets"—for practice, exercise and proper nutrition. An independent school coach may tell his or her athletes that they should not eat certain foods or take certain supplements, but the coach or trainer cannot fully guarantee that the athlete will heed these warnings. One effective thing that coaches and trainers can do, however, to combat erroneous and sometimes dangerous dietary practices among their athletes is familiarize themselves with the facts and myths about sports nutrition and make every effort to share this awareness with their athletes. In particular, coaches and trainers need to inform athletes of the benefits of proper nutrition and of the harmful effects that dietary "fads" and improper nutrition can and often do have.

Food for Thought—and Energy

The most prevalent myths which circulate among athletes concern what kinds of foods provide the greatest amounts and best kinds of energy. One such myth is that proteins will increase strength and build muscle mass. But other misconceptions—that a candy bar or sugar eaten before a game will increase speed or that caffeine will improve performance, for instance—are also popular among young athletes. In addition, the athlete may hear conflicting assertions such as that either skipping meals or eating large meals before games will, according to the source credited, either diminish or increase stamina.

The truth is that in order for any one food group to have a beneficial effect on athletic performance, it must be consumed in the context of a well-rounded, balanced diet. Proteins will not help an athlete unless the athlete also includes carbohydrates in his or her diet, and vice versa. In general, the average athlete's diet should be broken down in the following manner: 20–30% of total calories consumed should come from fats, 10–15% from proteins and 50–55% from carbohydrates.

Carbohydrates—Glycogen Production at its Best

As far as energy foods specifically are concerned, most sports nutritionists credit the carbohydrate group with providing the most and best possible supply of energy. When eaten regularly, and in moderation, carbohydrates provide a steady source of energy in the form of stored glycogen. Once stored, the body may call upon this glycogen for energy at any time. Sugar will provide an athlete with a "jolt" of energy, which is unnecessary, particularly if the athlete has glycogen on hand, and may be potentially detrimental. (One of the effects created by sugar's quick release of energy is similar to that caused by MSG in Chinese food—it has a tendency to induce hunger.) As for caffeine, young athletes should be informed that because caffeine causes a surge in motor units during muscle contraction, the United States Olympic Committee has refused to sanction its use. Furthermore, caffeine has been demonstrated to have diuretic effects which, in combination with heavy physical exercise and sweating, increase the potential for dehydration.

Eating before the "Big Game"

Athletes should eat pregame meals, if only for the energy they can provide during competition. An average meal takes several hours to digest, which means that while the pregame meal cannot significantly alter athletic performance either in terms of enhancement or debilitation, it can prevent hunger—and the distraction associated with it—during competition. The ideal time to eat a pregame or precompetition meal is three to four hours beforehand. This allows the stomach time to at least partially digest its contents, and so assures that the athlete will derive some benefits in terms of energy and sustenance. As for what the athlete can or cannot eat during a pregame meal, common sense should rule. Beyond obvious exceptions, chili dogs, pizza pies, etc., athletes should eat what makes them feel best, as long as it's healthy, and should eat as much as is necessary to prevent hunger during performance.

Carbohydrate Overload?

Young athletes indulge in some practices that, while not necessarily harmful, are nonetheless either unnecessary or misguided. One such practice is carbohydrate loading: the calculated increase of carbohydrate intake as a means for storing extra glycogens. In some cases, carbohydrate loading may be a good practice—for instance, when used in preparation for events that are sustained at 70% of the athlete's aerobic capacity for longer than two hours—marathons or triathalons, for example. However, athletes should be aware that carbohydrate loading should be done no more than twice per year and that considerable caution should be used whenever altering normal dietary intake. Recently, glucose polymers in powder and liquid form have received much attention as an energy replacement. These drinks provide carbohydrates in polymer form with favorable results and may be used in carbohydrate loading in place of other food products.

One a Day...

Vitamins receive the praise of many athletes in competition and training preparation. Vitamin supplements may be of some help when necessary requirements aren't met in the diet. However, taking vitamins as a method for *substituting* diet does not work and raises the real possibility that the athlete may overdose on vitamins. This possibility is not well known, even among nonathletes.

The Gatorade Factor

Electrolytes, contained in many "sports drinks", are assumed to prevent dehydration during sports activities and also to provide additional "bursts" of energy. Ads featuring pro football players drinking Gatorade on the sidelines are one way in which the myth is perpetuated among young athletes. But in this instance, as in others relating to sports diet, *simple* is once again better. There is no drink on the market today whose benefits to an athlete outweigh those of plain, cold water. Nor, for that matter, is there any fluid more important than water to good sports nutrition. Athletes who practice restricting their intake of water, in the belief either that it will facilitate weight loss or that water causes muscle cramping, should be quickly informed that the body needs to maintain an adequate fluid balance to allow cooling to take place and to avoid dehydration which can predis-

pose the body to serious heat illnesses, not to mention disturbances in muscle contraction. Cold water has an increased absorption rate, does not contain sugar, and is therefore the perfect antidote to these and other conditions. To receive maximum benefits athletes should try to drink between 16–20 oz. of water every two hours before competition, with 4–6 oz. every 15–20 minutes during competition. Coaches and trainers may wish to monitor their athletes' water loss by weighing athletes before and after heavy practices.

Salt—Too Much *is* Too Much

For reasons that are largely unclear, a myth has developed that salt tablets taken during practice or competition will reduce the likelihood of dehydration. However, large amounts of salt in the stomach actually draw water *out* of the stomach and therefore *cause* dehydration, rather than prevent it.

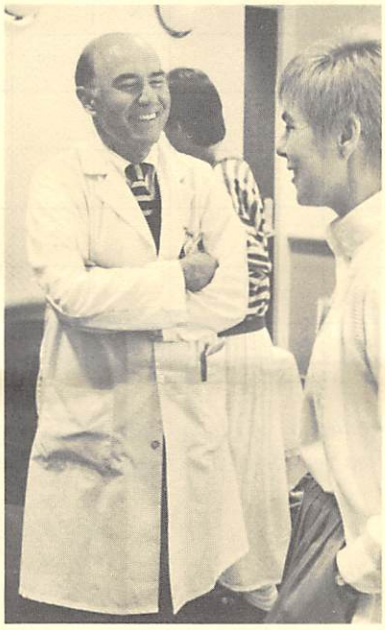
My Body My *Health*

The most detrimental myth circulating among young athletes is that somehow the rules of good nutrition that apply to others do not apply to them. For example, there are those who assert that because athletes burn up fats, they do not have to worry about them in their diet. Actually the amount of fat intake in the athlete's diet should be reduced, just as the National Cancer Society recommends that we all reduce our intake of fats. This sort of myth touches on the crux of the entire issue concerning athletic diet. Nutritional practices that are good for everyone are also good for the athlete—balanced meals, plenty of fluids, caution in regard to dietary fads—these are rules that everyone benefits from following, the athlete no less. An athlete's body may be finer-tuned, stronger or more adept than average. But this does not mean that it deserves less than the treatment all bodies deserve: healthy dietary practices and good sound nutrition.

ISHA Fall 1988 Conference Sold Out!

On October 20–21, 1988, ISHA and the Division of Adolescent/Young Adult Medicine, The Children's Hospital cosponsored a special two-day conference, *Health Issues in Independent Schools*. One hundred ISHA members attended the meeting, which was held at the Inn at Children's in Boston, listening to ten different presentations ranging from "Adolescence and Loss" to "Eating Disorders." A summary of the content will be printed in a monograph to be published later this year.

Coffee breaks allowed time for ISHA members to catch up on school issues and activities.(From left) ISHA Council members Mary Conway, RN, St. George's School (RI), Suzanne Casey, RN, Bancroft School (MA) and Marilyn Spencer, RN, Loomis Chaffee School (CT).



Keynote speaker Samuel Klagsbrun, MD, Four Winds Hospital (NY) visits with a conference participant. (At left) Robert P. Masland, MD, Associate Professor of Pediatrics, was our host from the Division of Adolescent and Young Adult Medicine, The Children's Hospital.

Duane Estes, director of counseling at Loomis Chaffee School (CT), led conference participants in a stress-releasing exercise during his presentation on helping adolescents cope with stress.

How many students attend your school?	50–60	76	107	149	160	195	200	230	230	275	362	390	400	120
How many hours a day is your health service staffed?	8a-4p	24 hrs.	7.5 hrs. M-F	12 hrs.	16 hrs.	12 hrs.	10.5 hrs	12 hrs.	9.5 hrs.	8.5 hrs.	24 hrs.	24 hrs.	24 hrs.	7:30a-10p M-F
Is your health service open on weekends?		will arrange		if needed	on call	10a-6p Sat.	7:30-12 Sat.	on call	Sat.11-12, Sun. 7p-8p	X	X	Sat.	Sat.	
Do you charge for routine visits to your health service?					In tuition									
Do you charge for overnight stays?														
What is the size and professional training of your health service staff?	2 RNs	1 RN 1 Ther.	1 RN	1N Prt. 1 LPN	1 RN 1 LPN	1 ft RN 2 pt RNs	1 RN 1 MD	4 RNs 2 N ast.	1 ft RN 2 pt RNs	3 RNs	1 N Prt. 6 pt RN/ LPNs	1 N Prt 1 RN	3 RNs	1RN 1 LPN 3 sub RN/LPN
Do you have a school physician?			X	2	X	X	X	X	X	X	X	3	2	
How often does your school doctor come to see students?			when needed	2x/ week	1x/ week	3x/ week	daily	2x/ week	2x/ week	2x+/ week	daily	8hrs./ week	when needed	
Is your doctor available 24 hours a day?		X	X	X	X	X	X		X	X	X	X		ER Dr.
Is your school doctor strictly a consultant, or does he consult and see individual students?			X	X	X	X	X	X	X	X	X	X	X	
Does your school have a health curriculum?	X		X	X	X		X	X	X	X	X		X	X(7th &8th Gr.)
Does the director of health services teach a class?	X	X		X	X			occ.	X	X	X			X
Does the director of health services live on campus?	1 RN does			both nurses	both nurses	1 RN does				X	X	X	X	
Do you have a no smoking policy for students?			X				X				Almost		X	Fall '89
Do you have a no smoking policy for staff/faculty?			X											Fall '89
Does your school have an athletic trainer?	X			X	X	X	X	X	X	X	Trying to add	X	2	
What emergency personnel do you have present at home athletic events?	Coaches 1st Aid Cert.	None	MD	Trainer MD	Nurse on call	MD Ambul.	MD RN	EMT	Trainer	Trainer on beeper	MD Nurse available	Trainer RN/NP (rot.)	MD, 2 trainers	EMT

In the last issue of the ISHA Newsletter, *our reproduction of Linda DuChene's chart, Health Services Provided by Boarding Schools, was printed with some errors. A corrected version of the chart is printed above. Our apologies to Ms. DuChene, and to anyone else we may have inconvenienced.*

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