Start

I p c e

N E W S L E T T E R

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Ipce is a forum for people who are engaged in scholarly discussion about the understanding and emancipation of mutual relationships between children or adolescents and adults.
In this context, these relationships are intended to be viewed from an unbiased, non-judgmental perspective and in relation to the human rights of both the young and adult partners.
Ipce meets once every one or two years in a different country, publishes a newsletter and a web site, co-ordinates the (electronic) exchange of texts and keeps an archive of specific written publications.

Introduction

In the Dutch Newsletter of the Association MARTIJN, web sites are mentioned and commented on. About Ipce's web site was said that is has an excellent and extended library. The commentator was amazed about the openness of Ipce in the reports of its meetings. The commentator strongly advised to read our Newsletters and our reports because important issues are discussed there in an open atmosphere and a high level.

Well, here is our next Newsletter with the report of our 16th meeting in May 2003 in Hamburg, Germany. Every meeting has its own atmosphere. For example, at the meeting in Athens, 1998,

there were only a few members but they have taken wise decisions. The meeting in Berlin, 2001, was said to be very inspiring and encouraging, while the meeting in Rotterdam, 2002, was said to be a bit dull or boring. Now, 2004, it was not boring. There was a fruitful tension between the young participants, who wanted *Action Now!* and the older members who want to think at first.

One of the topics was a problem I often had to face in circles of those who speak about relationships between children or adolescents and adult: depression. Also among Ipce members, depressions were mentioned. It seems to be the bad news and the rejection by society that make one depressed, which on turn might lead to a feeling of isolation, which on turn will strengthen the depression. But depression comes from the inside. The best way to cope with it is talking with friends, thus to have friends, thus to form and maintain groups.

That is what Ipce does: continuing its existence. Ipce has more than 90 members now in about twenty countries. Members talk with each other and gather good articles which may inspire others. By doing so, we try to support and inspire national and local groups, and individuals. By gradually expanding our web site, we inform the people who have serious interest in science and opinions.

In the course of time, several “Dear webmaster” letters have been received. On the web site, a new section will give a selection of those letters. And gradually, update by update, overviews by subject will appear on the web.

In the section ‘Articles’ of this Newsletter, you will find remarkable discussions within, and findings of APA researchers, as well as two messages from Dutch groups that clearly are able to survive and not to be depressed.

I also am not suffering from a depression. I will continue to work as your secretary and webmaster,

Frans

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A Statement

Ethics and intimacy in intergenerational relationships

'First, do no harm'

By Dr Frans Gieles

In: Ipce newsletter E 17, June 2004

Since 1993, Ipce members had discussions about ethics during their meetings.
I have listened to the members.
In this article, I will summarize and update the salient points of several opinions I have heard from 1993 until 2004.

Introduction

> "Ipce is a forum for people who are engaged in scholarly discussion about the understanding and emancipation of mutual relationships between children or adolescents and adults. In this context, these relationships are to be viewed from an unbiased, non-judgmental perspective and in relation to the human rights of both the young and adult partner." (Ipce Mission Statement)

Ipce Statements are not officially an "Ipce Opinion" because Ipce is a forum on which several opinions are present. Ipce does not vote about these kind of texts. About these statements however, most of the members will agree. In this statement, I report what I have heard from 1993 until 2004. This is not the end of discussion. The debate will go on. A debate is part of society - and society is changing.

Human rights and a reasoned discussion are a fundamental basis for the following ethical ideas about intergenerational relationships. One of these rights is that of choice of contacts and relationships with other humans. Contact is necessary for humans, and relationships can enrich life for both partners. This is the basis of reasonable ethical thought about intergenerational relationships.

The grade of intimacy in a contact or relationship is in the first place a free choice for both partners. This may differ according to the individuals and the situation. There is only one general rule or principle that counts in every relationship: ***Do no harm.***

Ethics

The guidelines we give here are ideals to strive for. They are meant as *global* guidelines or principles. Nobody can give exact *rules* for every situation. The guidelines provide concepts to have in mind and to take into consideration. One should, however, still make a case-by-case judgment. The guidelines are more or less tied to an actual culture and era, hence not eternal. Ethics change in the course of time, in the course of the discourse.

Ethics are not plucked from the air. For us, there are two ethical sources:

- *human rights* and
- *reasonable thinking*.

Our society *has* its rules and ethics about mutual relationships and intimacy between children or adolescents and adults. *Keep your distance* is the rule; fear of sexuality is its basis. In our vision, *this* is not ethical. But we are also part of this society.

This double position, criticizing the society we are a part of, results not only in our handing out sharp criticism, but also in formulating ethical principles that might be acceptable to the same society.

The guidelines

Freedom of choice

In *any* intergenerational relationship or contact, both partners, the adult as well as the young person, should have it in their power to regulate their own lives, their relationships and the grade of intimacy.

Each partner has the right to self-determination and the responsibility to acknowledge this right in the other. Therefore, both partners in open communication will at any moment choose the grade of intimacy.

- In *friendship* relationships or contacts, both partners have the freedom to withdraw from the relationship at any moment. Love and dedication are unconditional; they bind partners who are free and independent.

- In *dependency* relationships or contacts, (such as parent-child or teacher-pupil) love and dedication should also be unconditional, but freedom to withdraw does not exist in practice. So, extra attention should be given to the right to self-determination and the responsibility of both partners. Here, the grade of intimacy has two limits: complete distance is not possible nor wanted, complete intimacy will interfere with the dependency: complete intimacy asks for complete freedom, which does not exist in dependency relationships, thus complete intimacy is not possible in these relationships.

The grade of openness

Openness is a typical western value; many other cultures have the value to respect and maintain secrets. Openness within a relationship is a good value. **Openness to the parents is strongly recommended.**

Openness to others is a good value as long as they respect one's right to self-determination. So, openness to others may be good, but it is not always necessary and not always possible. For example, intimacy between males is still a great taboo, for instance, in most schoolyards. Or, in many families, the very existence of any form of a intimate life of a young person is a taboo.

Many young people prefer consciously to have their own secrets. They make their own choices and do not want to be protected. ‘Don’t treat me as a child’, they say. It is their right to have this freedom. The freedom to say *no* and the freedom to say *yes.* There is also a right of privacy.

The other side of the coin is that young people should not have to carry too heavy or unreasonable secrets. One has to take into consideration how the young person lives and how his environment may react.

Do no harm

This includes acting in harmony with the development of the child.

Harm can come from feelings of shame and dirtiness, learned from society. Harm can come from a society that uses power or violence to force the end of a relationship. One should consider this risk, as well as the risk of blackmail. The adult as well as the young person is vulnerable in this society nowadays. Thus: do no harm nor take the risk.

Start Omhoog

Report of the 16th Ipce meeting

21 - 23 May 2004, Hamburg, Germany

1. Members speak out

Two members have just been released from hospital although still unwell, a third member caring for one of the patients. Four others had to cancel their attendance at the meeting shortly before it, for other reasons. Fifteen people, members and guests, were present. They came from Germany, the Netherlands, the UK and two other more distant countries. The meeting was more or less in two languages: English and German. An important element of the meeting lay in giving members the opportunity for informal contacts with one another.

The introductions in the first round were:

- I am ... from ..., member or leader or webmaster of ...
- My situation is ...
- I am here because... and for the purpose of ...
- My plan is ...
- My questions are...

The members...

The members present were a mix of ages and histories: some had grey hair and had visited earlier Ipce meetings, others were young and were at their first meeting. Most people present are active people, active in groups or web sites, or are writing books, articles, gathering texts, and so on.

... and their situation

Only one member presented himself as being in a deep depression. All others mentioned problems, but also said to have balanced minds, energy, hope and courage.

The Germans

have had a difficult year. An infiltrator who had gone from one self-help group to another, had won the trust of many members, and had gone to the police, written articles and made three TV programmes about his experiences. The same journalist carried out a similar action about five

years ago, be it on a smaller scale. The group in Munich especially had to cope with a lot of house raids and arrests. Most of them are free again now, but the group still cannot function. One has to wait until all court trials have been held.

Other groups have had also problems, among others, the three Berlin groups. Two of them still exist, but now more or less as informal groups without any further organization such as address lists. There were five arrests. These people are getting help from the groups. The Bremen group has changed its place of meeting from a public to a private one. The Rhein-Ruhr group has closed - out of fear. Before this undercover operation, there were ten active groups in Germany. After it, there are three active and five 'sleeping' or pausing groups. All groups know people who have retired into their shells, re-isolating themselves in their private lives out of fear. So, the infiltrator's action was 'successful'. Still, Hamburg still has a good functioning group of people who know each other quite well. The AHS still exists and is active, though cautious.

The Germans are also plagued by strange new laws as well as pressure from the media and some so-called 'child-advocate' -- factually very right-wing -- groups in the country. "Cold times", so was said. In Germany, *words* can be illegal in a specific context. For example: nazi-propaganda words are illegal in the context of a nazi web site, but allowed in a critical article. Likewise, the now notorious "Stephan.txt" has been declared pornographic in the context of a pedophilia-related web site. Thus, because of that context, some words suddenly *become* pornographic. That verdict, however, has been overruled now in appeal. Some people or groups are studying now if this new law could be unconstitutional. Groups such as Nazi groups can legally exist as long as they keep themselves within the limits of the law. Likewise, ped-groups can exist on the same condition.

A new law forbids one to *speak* positively about crimes, whilst more intimate contacts with children are seen as abuse and thus a crime. Clearly, speaking positively about it is regarded as dangerous by the public, whose opinions have changed a lot in Germany. This provides police with grass roots support and much room for oppression. The fear is that laws of this kind will also be adopted at the European level.

However, there are increasingly more critical people, among others certain scientists, who form a counter movement against this trend. As an example, a professor was mentioned who not only spoke about 'abuse', but also of 'the abuse of abuse' within the abuse-ideology. Pedophilia was presented as a normal phenomenon, a variance among humanity, that does not necessarily lead to '*real* abuse'. Another example is the *Arbeitsgemeinschaft Humane Sexualität,* , who sees sexuality as a positive force in human life, regardless of its orientation.

In the Netherlands

the group JON still has problems after the house raids and arrests. Nevertheless, the group

functions, helps its members and continues with its talk sessions and publications on the web. An intensive defence of the group against accusations has helped. It has been formally declared that, as a group or organization, JON is not the subject of any criminal charges. Nevertheless, the group has lost members and leaders, because their fear was stronger than their hope or courage. In future the group will better inform its members about the laws and their legal rights. It has become apparent that not all members knew their rights or other laws very well, or were otherwise unable to cope well with interrogations, which are well-known to be quite manipulative.

Other groups are still functioning well in the Netherlands: other self-help groups, the Association Martijn, the Magazine KOINOS and others. KOINOS has art and fiction as its central themes. The publication is felt to be more a hobby rather than a political action. Still, art can change society. The magazine includes other languages now and thus is running successfully as an international medium.

In the USA

NAMBLA's situation is still more or less problematic. There is a lack of capable and active people available for the Steering Committee. The group has re-organized itself by becoming one group and dismissing the chapters.

The moral and juridical climate in the USA is far worse than in Germany. Nearly every new law or regulation is absurd.
The author of a book, *The Moralist*, had to impose censorship on it by dismissing a large number of passages in the second edition. The author lost his job because of his writing. It is seen as "Dangerous" by *Dallas Voice*. Texas is very conservative. Journalists refused to read the book or to review it. The gay world, or more correctly, a part of it, has received the book in a better, more critical way. The book is not an essay, but a novel, made to raise ethical and aesthetic questions about love and law, morals and ethics. The core of the novel is the hypocrisy of the moralists - not boy love as such. This is only a concrete example chosen because of the controversies it raises. The book is a challenge to re-think morality. As is known, books and arts can change politics.
The very conservative right wing in the US is concentrated around many radio talk shows that constantly attack "the liberals". The liberals themselves, however, do not listen to those radio programs. They prefer to read books and watch more humoristic TV shows.

In the UK

it is not possible to have a group, but people know and help one another effectively. In the UK a real witch hunt is going on, fed by absurd laws, very powerful police who seem to forget the laws, obtrusive journalists, panic-provoking media with ‘name and shame’ campaigns, and a lot of TV programs, which all constantly speak about those "dangerous criminals" named

paedophiles. A new law forbids "grooming", whatever it exactly may be, so even speaking with a child can result in severe punishments.

From the south of Europe was told

that the climate there remains more liberal and not as conservative and right-wing as in Northern Europe. People in the south have more relaxed attitudes and follow their gut-feelings, being less rationalistic. Strange laws were not seen in the south. There were ‘scandals’ in Portugal and child porn raids in Italy.

As has been described in the previous Newsletter, the Danish group DPA has folded. A new group has arisen like a Phoenix and replaced the web site, but we do not know more about the situation in Denmark. A lot of other countries have no groups or organization at all.

Purposes, plans & questions

Most members present were mostly there to meet the others in person and to learn about their well-being or problems. Within Ipce, most communication takes place by electronic means, but it is good to meet the person at least once a year. While describing their motivation for attending this meeting, several members referred to our meeting in Berlin, 2001, which is said to have been very inspiring and encouraging. Also Copenhagen, 2003, was mentioned as such, while Rotterdam, 2002, was felt as more or less dull. People hoped for inspiration and encouragement.

Plans were to continue and to try out new kinds of action. Questions were about strategy and ways to activate and organize people.

Self-help and other groups clearly have had, and will have to face problems like infiltration (Germany, earlier NAMBLA), false testimonies (the Netherlands), difficult laws and prejudiced journalists - and so on. How to prevent these?

Strategy

Two different ways were mentioned, in addition to a general rule.

In a group like the NAMBLA Steering Committee, the leaders have responsibility for the safety of its general membership. Within such groups, one Steering Committee member must know another very well. To know a lot about one another may prevent infiltration with a false identity.

In the case of other groups, such as chat groups on the internet, the use of anonymity and

nicknames is more usual. One does not know one another's name and address, so nobody can make it public. For good communication, so has been said, one needs no real name. People who want to meet one another in real life, can make their own individual choice. Such a group exists in the Netherlands, a group of mostly young people full of ideals and idealism, some of them active on their own web sites or otherwise - maybe later becoming the successors of the grey-haired people.

However, infiltration by ill-motivated people cannot be entirely prevented. One has to be conscious of the risk. Anonymous chat sites are quite easy to infiltrate. In more personal groups, it is more difficult but still proven to be possible. The German infiltrator had prepared his job very carefully. He had a real existing address, a good story, and even was sometimes accompanied by two young boys who also told lies.

So, the general rule is: do or say nothing that you won't have published on the front page of the newspapers. This requires self-discipline. Meetings such as we have now, do not interest newspaper journalists. What we discuss here - and publish now - is not the kind of information they or the public want. Because there is always a risk, one should also be courageous enough to remain active, to form and lead groups, which might be organized according the Steering Committee model or the chat site model. Both have their risks. A certain level of publicity is needed, otherwise new people cannot find the group. There is no choice, as long as you want to reach and help people - and because there are not many people really active in this field.

These people should be also able to create leadership: to have the knowledge, vision and capacity for organizing human power. For example: do not ask for more active membership of board members during a meeting: prepare this and ask people personally before. Also: divide tasks so that simple concrete tasks can be undertaken by new active members.

Risks? *Life* is risky. Living implies the expectation of risks and problems. A group as a whole has a shared responsibility, but no group can be trusted completely. Thus, you can trust only yourself - and remember the general rule given here above. Do not be surprised if you discover your phone is tapped, as happened in the Netherlands. Caution should be your style of living. But it should also include being courageous and active in helping one another, and studying carefully the laws of your country.

For example: a person, arrested on the basis of false accusations is scarcely able to defend himself because police or prison guards may block every communication. He needs help, and the helper needs a good knowledge of the law and the judicial system. An idea is: make pamphlets for your members with the juridical knowledge they must have.

Another example is this meeting. Different feelings and ideas are expressed about the taking of photos at informal moments like meals in a restaurant. At the one end of this spectrum are those who express fear of wrongful use of photos of a group, which serve to help those who

quickly speak about 'networks' in their investigations or infiltration. They point to the fact that in several countries personal rights and freedom are greatly limited. At the other end of the spectrum are those who say we should not be led by fear, and who will not limit their rights and freedoms through fear. The sensible middle path is: caution and prudence along with respect for those who refuse to be on a photo.

Some of the members present say that they have been very much helped by their group over the years. Personal consciousness grew, stress became better to cope with, we have learned to live with our feelings within the limits of the law, and so we may have our feelings without guilt or stress.

Vorige Start Omhoog Volgende

2. Presentations and proposals

a. Evolution or Extinction, A New Direction for a New Millennium by Sir John

A video compilation: "British Justice" shown as an introduction to the seriousness of the escalating anti-pedophile hysteria in 21st Century Britain.

This demonstrates how British 'justice' has operated in "Operation Ore". Hundreds of people who were accused of downloading child pornography were suddenly arrested by a small army of armed policemen who forcefully broke into their houses. Their homes were wrecked and their lives [were] destroyed - they lost their job, their income, family, friends and their freedom. A detective in charge of the operation said that it has been proved that people who download such pictures are very likely to become abusers later on - which is not true. We saw the same detective instructing police officers to act respectfully against the arrested, but the images we saw told the opposite story.

John has gathered a lot of documentation of the way police 'protect the children' against the great danger of 'serial pedophiles' – predominantly people who only had downloaded some pictures. This is common and daily practice in the UK, and this trend will go on. Many people are constantly monitored by police or media. The public takes revenge. There was an arson attack on the home of a known pedophile, which he shares with his elderly parents. The father was injured whilst escaping, and they were all lucky to escape alive. The offender admitted to the crime, and that he knew the premises were occupied, yet only got only eight years, where a longer sentence would be expected. Any sexual act can lead to lifelong imprisonment, while a drunken driver who kills people - murder - get only one or two years.

A short lecture

John presented a summary of the related paper, "Evolution or Extinction?, and shortly before the meeting sent it to the secretary. Due to the lack of a photocopier at our meeting place – and, in a moment of forgetfulness from the secretary, there was only one specimen of the paper present. Here it follows in full:

Evolution or Extinction – A New Direction for a New Millennium

Twenty five years have now passed since the relentless campaign of hatred and spite against so-called "pedophiles" began in earnest in the United States, spreading initially to Britain, then to Europe, Australasia, and eventually all continents. Whilst the increasing offensives from numerous flourishing organisations - and the individuals who are their driving force - have evolved over the decades, the 'victims' of these attacks remain on the defensive, using basically the same old arguments and methods in the increasingly despondent hope that reason and enlightenment will triumph over prejudice, ignorance, and loathing.

Advances in technology have greatly assisted the "pedophobes" in gaining a strategic advantage in the monitoring, persecution, entrapment, and eventual prosecution of individuals and organisations. With the exception of the use of computer technology for the exchange of information, and the creation, distribution and encryption of "pornography", the victims of these tyrannical xenophobes have remained in the 'dark ages' of the 1970's when honesty and rational debate were virtues.

Blatant lying and deception by politicians, journalists and 'academics' has now become so commonplace in western democracies that it is expected and accepted. The consequences when they are caught and exposed are becoming so small that they no longer act as a deterrent. What do we have to offer in return? Truth and reason - but does anyone want to listen? To hell with the trust!

Instead of responding to negative comments and defending inter-generational relationships, perhaps it would be better for *us* to ask the questions, and lead attention away from the so-called "predatory paedophile" to the issue of child sexuality, and forms of child abuse perpetrated by the State.

- Why do children actively seek sexual contact not only with their peers, but also with adults?
- What action is the State taking to deal with predatory children who are intelligent and determined enough to use technology in the pursuit of knowledge and sexual experimentation?
- Why do children deliberately enter Internet chat rooms which they know are sexually explicit and may lead to a physical encounter?
- What about the widespread "abuse" of children by adults who are *not* paedophiles?

- What are Governments doing to protect children from the serious harm caused by passive smoking, careless and drunken drivers, domestic violence, bullying at school, and exploitation by ruthless advertising campaigns?

Surveys conducted in the UK show that children are far more concerned about violent and psychological abuse at home and being bullied at school than "Internet paedophiles" (is this a new species?), or the very low probability of being harmed by a physical encounter with a sexual "predator".

It is said that "attack" is the best form of "defence", and I have personally found this to be correct. Politicians, State Authorities and journalists rest assured that at last they have found a minority group that they can persecute without fear of retaliation or support from other sections of the community. In the infrequent cases where others do come forward in support of intergenerational relationships, they come under severe attack on their personal integrity, and risk losing their jobs.

It is therefore no surprise that these courageous, open-minded and rational persons are now falling silent. If, however, the integrity of the persecutors is seriously questioned, their hypocrisy concerning child welfare is exposed, and the financial fortunes that are made at public expense are revealed, they will be more concerned with defending themselves than attacking us. How sincere is the United States Government in protecting children from sexual "abuse" when their agents orchestrate the rape of Iraqi boys held in prison without trial? Those responsible must pay dearly for their crimes.

We must no longer fear the state - Let the state fear *us,* not because of what they believe we do to their children, but because of what they know we can do *them.* Humiliate them, just as they humiliate us.

For 25 years we have suffered the rejection and misrepresentation of our beliefs and culture. We are deprived freedom of speech, liberty and justice. However, that is now the least of our problems - the persecution has now entered its next stage. As with Christians, Jews, Homosexuals, Communists, Black people and "Witches" the baying mob wants blood. Many of us now fear for our lives, not just our liberty.

Over the past few years there has been an alarming number of murders of alleged "paedophiles". These cases receive little, if any, attention from the media, and when they are reported, there do not appear to be any further reports about the prosecution and conviction of those responsible. The murder of persons convicted of a sexual crime involving a child are alarming enough, however there have been several murders of persons who have *not* been convicted of any crime against a child, but have faced allegations. In one case a man was murdered after being found not guilty of malicious allegations - he was exonerated. Equally disturbing is the increase in the number of suicides by men accused of sexual crimes against

children, and not convicted. In some of these cases the individuals have not even been charged with an offence or prosecuted, yet apparently the stigma of being accused of such a crime, and the abuse to which they are subjected has driven them to take their own lives.

It is a situation which is heading in the direction of a 'holocaust', and if we do not evolve and adapt to the new world environment, we are in danger of extinction. I believe that it is time for a new direction - new policies and tactics, adapted to deal with the immense changes that have occurred in our society during the past decade. The very nature of Ipce needs to be re-thought. The only hope for the future is to forge alliances with different groups in society. For example, the former support from Gay groups has been almost completely lost. We must ask why, and what we can do to regain their support, and also how can we persuade others to listen, learn, and begin to accept the basic concepts which form the foundation of our beliefs and aspirations.

Diversity is the key to the survival of life on this planet, and I believe that it is the key to the survival of Nature's "insurance" -paedophilia. By embracing a wide number of issues which concern the welfare and education of the young, there will be less opportunity for adversaries to stigmatise, criticise, attack and condemn our culture and beliefs. "Paedophile" groups and organisations must go, to be replaced with "Foundations", "Institutes" or "Academies" concerned with all aspects of the young and their role in society. This can include technology, health, recreation, communication, the arts and the effect of the environment and pollution on the development of the young. The subject of child sexuality and inter-generational relationships being just one of the many subjects researched and debated.

Campaign instead for a better understanding of the young, and role they play in society - their aspirations, individuality, and the right to make decisions for themselves. With Rights come Responsibilities. Societies outside of Western culture achieve this through "initiation rites", and this may hold the answer to the Western problem of escalating crime and antisocial behaviour among those trapped in the "no-mans-land" between the onset of puberty and the attainment of legal rights at varying ages.

Turn our adversaries' propaganda against them - accuse *them* of child "abuse" through their denial of basic human rights to the young - we should all be free to explore and express our beliefs, culture and sexuality in peaceful harmony regardless of colour, race, gender - and age.

Some of these topics have been discussed in various forums, however the emphasis of Ipce and other similar groups is on sexual relationships between adults and the young. As long as this area remains at the top of the debate, the hostile attacks will continue... and increase in their ferocity. In order to ensure our survival we must evolve and adapt to the changing climate of the 21st Century, or accept the fact that extinction is just around the corner.

Discussion

In the US, 20,000 people were accused of downloading child pornography in "Operation Landslide". However, Landslide was not a service for child pornography, but only a service to pay by the Internet. Only a few clients had factually downloaded child pornography. Moreover, a lot of pictures were not pornography at all.

A kind of paranoia seems to have spread itself over the Anglo-Saxon states. The authorities create it; the media support it. If the media do not swallow it, then the public will not react in the way they do.. Large sections of the media present unnamed scientists or other 'experts' constantly to assert how dangerous sexuality is in childhood and how dangerous "a pedophile" is.

The tabloids describe many kinds of sexuality below the age of sixteen as "pedophilia", which becomes the equivalent of a future murder. The murderer of an adolescent, without any sexual motive, has been called "a pedophile". Anybody who speaks positively about childhood sexuality is seen in the same way. Such a person will quickly see his or her face in the newspapers and may soon hear the knock on the door. One loses house, job, relations and children. This happened, for instance, to a lawyer who had defended people who had only some naturist pictures. He had the same pictures in his possession for the defence. In the US, a picture of a child in the bathtub will be enough. There, everyone, even if one is not convicted, has to register himself.

So, do not be surprised by the high number of suicides and even murder of 'pedophiles'. Sir John has documentation about eight cases of murder, including murder of unconvicted people.

Thus, says John, we have to turn the tables and go on to the attack instead of only defending. We should raise different issues. We should attack language use like "predator", which is associated with a beast of prey, an animal, not a human. We should point towards the top of the lists of problems children say they have. At the top are: quarrels and other problems with parents and peers - not pedophiles. Most children are killed by cars, drugs and passive smoking - not by 'sexual predators', who nevertheless are at the head in the list of rules and regulations to protect children. If a 'pedophile' offence is not a murder of the body, he will still be punished heavily because he is called "a murderer of the soul", which is worse.

Thus, raise the issues that are real dangers for children. Lay the issue of sexuality aside and concentrate on the real dangers. Sexuality functions as a concrete wall. There are a lot of organizations that have an eye for those real dangers. Thus, join such organizations and political parties, be political active over a broad range. All those organizations need active people and people who are able to take leadership. There are human rights associations and committees. Work for child emancipation, not especially for emancipation of inter-generational relationships.

Three examples

An example is NAVSCIP, the National Association for Victims of State Corruption, Intimidation and Persecution. As a consultant for this Association, Sir John attended a public conference organised by the National Probation Service (a section of the Government Home Office) concerning prisoners who are just released and often not have a house or an income. The theme of this conference was the housing of sex offenders. A well known ped-hunter , Ray Wyre, was a guest speaker, and he was wreckless enough to make statements concerning a high-profile child murder trial which had recently begun. Mr Wyre gave information which was *sub judice,* and subject to a ban on public disclosure. Sir John submitted a complaint to the Attorney General's Office, together with a tape recording of the speech as evidence. As this was evidence of possible contempt of court and an attempt to pervert the course of justice, the Attorney General was obliged to conduct a thorough investigation of Mr Wyre, and also the Home Office which was responsible for the conference.

One of the topics at that conference was: "Should one separate 'predator' and 'victim' definitively? Sir John pleaded in favour of bringing them together and clearing the air by speaking out their feelings, listening to each other and reconciling both parties.

Another Ipce member organized a conference about Human Rights in Denmark. This conference has had influence on politics and jurisdiction.

A further example can be found in the book *The Moralist*. The plot in this novel tells us that the leading character in the book, Red Rover, becomes active after a friend of his was accused, by an alcoholic mother, of child sexual abuse, while factually it was a purely consensual relationship. Still not convicted, his friend loses his house because it is fired and he has to flee fromthe city. The plot tells us that Red accidentally has an encounter with the nephew of the other leading character of the book, Mister Barnett, who is The Moralist himself. The nephew has a tape in which he is sexually abused by The Moralist himself. Nephew Bill and Red Rover go to the media and hand over the tape. In an interview with the media, Red accuses the so-called Sexual Abuse Industry and their witch-hunt for violating human rights under the banner of protecting children. "Tomorrow, they may knock on your door", Red ends the interview.

Thus, Red used the media in an effective way. This was the next topic of the Meeting.

b. Effective Use of the Media

The example of Red Rover, the leading character in the novel *The Moralist,* given above, is good. In an interview with one of the media, the interviewer has his or her own agenda. You should know and realize that this agenda has only one word: sex. This is a pitfall. Speaking about sex does not work. So, it does not work to follow their short agenda. Thus, simply do not reply their questions, usually put in 'negative words', and go to the attack to set your own agenda and put it in 'positive words'. This is what Red Rover did in the novel in a TV interview:

"They say your real agenda is to normalize sex between adults and children."

"No, my agenda is truth and justice and common sense. I want to end the insanity of this witch-hunt, so we can look at this sensitive issue with clearer, more reasonable eyes.

Your agenda might have topics like

- Privacy,
- Human rights,
- Freedom of expression,
- Civil rights,
- The right to personal relationships, and
- The right to hug one's own children.

Quote from the book

Here is a quote from *The Moralist* (page 468-470 in the first edition, page ...-... in the second edition) in full.

Red sat across from a youngish woman, pretty in the face with long sandy hair falling to her shoulders, but too skinny, her once soft girlish features turning sharp and her voice low and masculine. TV journalism did this to women; it turned them into skinny men with tits.

"Mr. Rover, where did you get that tape?"

"As a journalist, I'm sure you understand the importance of protecting the confidentiality of your sources, Ms. Taylor, but I can tell you that the tape has been verified as authentic. Even more important than the specifics of Bull Barnett's personal behavior, the tape exposes the hypocrisy of the witch-hunt hysteria that has gripped this country for twenty years, destroying the lives of thousands of decent people. I know of one young gay man who was prosecuted for his relationship with his sixteen-year-old lover. They were living together with the parents' knowledge and approval. After his prosecution, he was forced to go to sex offender school and to post a sex offender sign outside his home; as a result, vigilantes burned his house down. To me that's wrong, and I'm speaking out against it."

"Mr. Barnett's people are saying this is a smear campaign cooked up by the international pedophile conspiracy. Are you part of that conspiracy?"

"That's nonsense; it doesn't exist. The only conspiracy I know of is the witch-hunt conspiracy that's been going on in this country for twenty years, and spreading around the

world. It's an industry now, based on money and phony science. There's a legitimate study published in the *Journal of the American Society of Psychiatrics* that exposes that phony science, and the witch-hunt conspiracy is doing everything they can to discredit it, because they don't want people to know that their hysteria is based on a foundation of myths, lies, and hypocrisy.

"Regarding Mr. Barnett, I wish he' d been more honest with himself about the reality of his own boy-love feelings and the important role that plays in our culture. Socrates, Michelangelo, Shakespeare, Goethe, and Tchaikovsky were all boy lovers, and I could name you twenty more. Lord Bayden Powell who founded the Boy Scouts. James Barrie who wrote *Peter Pan*. The American writer Horatio Alger, who wrote the famous stories for boys that Richard Nixon used to love so much. You want me to keep going?"

"How did the tape come into your possession?"

"It was purely by coincidence. After verifying that it was real, I released it to the press, because I want to expose the hypocrisy of the witch-hunt conspiracy. Bull Barnett has been an instrumental force in that conspiracy. "

"So you wanted to 'get' Bull Barnett."

"No, I want to expose the web of lies and injustice of which he is a part. Most people don't realize the damage this hysteria has done to our civil rights. Did you know that now you can be arrested for taking nude pictures of your own children ... teachers are afraid to touch their students, fathers are afraid to touch their sons ... people are being locked up in prisons and mental institutions for life, long after they have served out their sentences ... you can be arrested for drawing a picture of a nude child. It's insane, and don't think that this doesn't concern you, because the police and prosecutors are very adept at expanding these powers into other areas of law. If drawings are illegal, why not writing? Maybe we'll be burning books next. The witch-hunt hysterics are already advocating that. It's time that we woke up to what's going on here, before it's too late ..."

He looked directly into the camera,

". ..before the jackbooted thugs kick down your door. Don't be so sure it can't happen. It can and will."

"They say your real agenda is to normalize sex between adults and children."

"No, my agenda is truth and justice and common sense. I want to end the insanity of this witch-hunt, so we can look at this sensitive issue with clearer, more reasonable eyes. Other cultures have idealized these kinds of relationships as a blending of devotion and teaching into a higher form of love - the ancient Greeks, medieval Persia, seventeenth-century Japan, not to mention all the primitive societies. We are the ones who are out of step with a natural

phenomenon that has existed throughout human history."

"That sounds like you believe that pedophilia is okay."

"I believe it's a much more complex issue than that, and as long as we are consumed with this witch-hunt mentality, we're not going to get anywhere except to ruin the lives of decent caring people and shred our own civil rights in the process."

"But haven't you ruined the life of a decent, caring man by releasing this tape?"

"No; ... like I said, I wish Mr. Barnett had been more honest with himself and with us. He has led the charge in this witch-hunt, when he himself is a boy lover. That's hypocrisy. That's dishonest. And it's symptomatic of the dishonesty of the entire witch-hunt conspiracy."

She started to ask another question, but he cut her short,

"Thanks, Valerie. That oughta be enough. You got some good sound bites there."

"But I had some more questions."

Unclipping the mike,

"What? What could you possibly ask me that I haven't already answered?"

"Are you a member of any pedophile organizations?"

"No, I'm an artist and a citizen concerned about this threat to our constitutional freedoms of thought and expression."

"But you write for a pedophile magazine."

"I write for a magazine that discusses boy-love issues. It's an opportunity to express my views, the same as talking to you now."

"And your name appears on an international e-mail list of pedophiles; isn't that evidence of a conspiracy?"

"No, it's like-minded people sharing their thoughts. You see where this is going? You're trying to indict people for what they think and who they hang around with. That is the death knell of our constitutional freedoms in America."

"So you write for a pedophile magazine, your name is on a pedophile e-mail list, you speak on pedophile topics, why are you afraid to admit that you are a pedophile?"

Red smiled,

"I'm not. I'm a boy lover. So is Bull Barnett. The only difference between us is that he doesn't admit it. Instead he launched a campaign against it. That doesn't make sense to me. I guess you'll have to ask him to sort it out, and I'm sure someone will. Thanks, Valerie. I appreciate the opportunity to have my say."

With a big grin, he stood up and stepped off the stage.

c. Again: Use of the Media
A proposal from a Danish member

Regrettably, this member was ill, so he was not able to take part in the meeting. Before, he had written:

Alternative Internet TV & Internet Radio - for us.

Below are some examples of Internet Alternative Media that might inspire us to acquire similar Internet tools for our struggle. For example concerning, amongst other things, the struggle for freedom of speech and for the right to organize, which is what the Danish group has been denied in practice due to social and media pressure. None of these examples you can see below has, however, anything to do with sexual politics, which of course is a pity in itself, but nevertheless .... examples they are. However, I do think there lies a future strategy for us here.

With the joint efforts of Ipce, I'm sure that we have the capacity to, amongst other things, create Internet streaming TV & Radio. I've talked with our mutual friends in Denmark on this matter and it is confirmed that it is a very realistic project indeed.

I know I personally want to create Internet streaming TV & Radio and that I'll get it if I live long enough. Even concerning this future streaming Internet TV I've already had some success. But why don't we all get together and do the same thing as soon as possible? The more of us who get involved in this project the easier it will be for everyone.

A pertinent question:
What is in it for Ipce? What can Internet TV & Internet Radio do that Ipce currently / at present cannot do?

One very good example is:
If we had had Internet TV at the time of "The Rotterdam Report" some years ago

(which by the way, as we all know, was very poorly covered by the media & actually only mentioned in Holland)

[the writer refers to: Rind, B., Bauserman, R. & Tromotitch, Ph., An Examination of Assumed Properties of Child Sexual Abuse Based on Nonclinical Samples, Paper presented to the symposium sponsored by the Paulus Kerk, Rotterdam, The Netherlands, on the 18th of December 1998.]

then we would have had our own permanent media outlet which every country in the world would have had access to. If that had been the case then, then we would have, to a very large extent, become independent of the established media censorship - we would now have been on the road to winning the media battle of freedom of speech & freedom of expression and fair communications.

Having a potentially popular permanent archives for the world to see would be an incomparably more powerful tool than anything we've ever seen so far. I am not degrading the Ipce scientific written research documents in any way, which I know is the hard core substance everything else is built upon, but what I am saying is that reaching large numbers of people is the potential virtue of Internet TV & Internet Radio. So lets supplement the Ipce archives with Internet TV & Internet Radio.

People like Brongersma who went on Dutch TV & Bill Andriette who went on the Larry King Show are splendid demonstrable proof that we have people who are willing to come forth publicly which of course is the essence of TV & Radio. I too am ready to go public if there is any desire or need for this - even as soon as our May meeting if no one else is inclined to do so at present and if there is a consensus in favor of such step.

Check this out if you have time:
Overview of Great International Alternative Internet TV, Internet Radio, Internet Newspapers and Internet Magazines:

- RantTV.com
  Check it out at = http://www.just-well.dk/overview.htm
- Freedom TV - Alternative Media Outlet TV Industrialpolitics.com
  Check it out at = http://www.just-well.dk/overview.htm
- InfoWars & The Voice of Freedom - Click here
  - chat with others watching the same feed as you RIGHT NOW
  Check it out at = http://www.just-well.dk/overview.htm
- Internet Magazine The Torch - in English: Click here
  Check it out at = http://www.just-well.dk/overview.htm

- Internet Newspaper Truth Out - in English: Click here
  Check it out at = http://www.just-well.dk/overview.htm
- South Africa "Talk Radio"
  Check it out at = http://www.just-well.dk/overview.htm
- Please download free Winamp for the best access to and overview of the best international alternative Internet TV & Radio in the world
  Check it out at = http://www.just-well.dk/overview.htm
- Home = http://www.just-well.dk/overview.htm

d. Proposal from Jay Baskins: *This Too Is Love* web site

This proposal is already published in the Ipce Newsletter # E 16, May 2004. To quote it shortly:

> I would like to see a web site opened that would be called "This Too Is Love." In it, biographical, auto-biographical, and fictional accounts men and boys who have loved each other would be made available to the general public. Some of the accounts might contain fairly graphic material, and some not. But it would not be a site for erotica.
>
> I would like to this site be a place where current writings sent in for publication would be considered along with some older pieces of writing. It would contain both fiction and auto-biography, and perhaps even some research that was done from a narrative perspective (such as Sandfort's).

e. Discussion and decisions

Streaming Internet Radio & TV?

This kind of publication via the Internet asks for special software, for making it as well as for downloading it. It asks for a great bandwidth, thus for a good provider - and supposedly for quite a lot of money. How to find a provider for 'sensitive content'? Wouldn't the site quickly be removed?

The content has to be broad: "Boy Love" as a theme does not work; "Human rights" will be better. Lots of people are active for civil rights, and there are good critical scientists. One does not see them on TV; one has to go to the library. But how to find people to make clips, how to find people who want to appear before the camera, how to make enough programs for one or two hours each day?

It seems to be better to make a small start by making clips on a video or a cd-rom. Three members said they would make contact with the Danish member.

This Too Is Love web site

Good idea. Books, sites and shows with true stories told by people are quite popular. People tell their story or narrative, others recognize it. The NAMBLA booklet "Boys Speak Out" was quite popular and had to be reprinted. Providers accept true stories. Such a web site already exists, but this is more or less pornographic, which we do not want. The webmaster will make contact with Jay Baskins. He will ask Jay to start on the content, Ipce's web master will manage the technical side of the job.

Turn the tables, use the media

Indeed, there is much hypocrisy in society, and there are a lot of groups and sites that expose this, especially anti-conservative groups expose the hypocrisy of the conservatives. They attack their enemies by exposing their actual activities.

"Enemy", "war" ... For some of us this means a change in our way of thinking. We are not used to these concepts, and some members protest against this way of thinking, because one should not do the same as one's opponents. Can you combat fire with fire? Others say "Don't be willing to offer the other cheek." For example, from the UK was said: "It *is* war in Britain!". If I am attacked, I will fight back.

But "war" and "enemy" are metaphors. The 'enemies' are not concrete people, such as policemen, but a mindset: ideas, trends, feelings, laws, practices, political power - that factually can destroy the lives of people. Do not attack people, but ideas. Do not attack society as a whole, because we are also part of the same society. Attack certain ideas.

Assert, for example, that curtailing free expression of thoughts does not, in fact, protect any child. Describe what is really happening in the so-called treatment centres for offenders - people do not know about this; they are frightened if they hear it. Tell people what the state does *not* do for the welfare of children, and what states do in practice *against* that welfare. Talk about the lack of prenatal care for the poor. Make data bases of all this, ready to use them if needed.

OK, another member said, good ideas, but now the action! Who're gonna do this? We discuss a lot of details here; we hear and say a lot of words, but we need action! However, another said, for good action one needs to discuss all details.

Further, Ipce is not an action group but only a forum. People might be inspired by ideas and take action themselves or in their own groups. An appeal for action has been heard at several Ipce meetings, especially by the young people. But Ipce meetings have inspired people to undertake their own actions themselves. This is especially said about the Berlin Meeting in 2001. The same might happen now, albeit difficult times now. The German and Dutch people

are still shocked about what has happened. But we might help each other.

A member who had to leave before the close of the meeting bid his farewells, pleading for the continuing production of books, articles and web sites for access by the public. And he reminded us not to forget writing to the newspapers as well as the importance of mutual help.

Vorige Start Omhoog Volgende

Vorige Start Omhoog Volgende

3. Internal *Ipce* Matters

a. Report of the Secretary and Webmaster
May 2003 – May 2004

" In May 2003, at the start of my sabbatical year, I handed over all my tasks and data, e.g. access to the bank account and the web sites, to two Ipce members who promised to take over the tasks. Regrettably, they did nothing. Therefore, there was no report of the Meeting 2003, no Newsletter, no update of the web sites, no files ready for it and no financial report. Nobody knew where the money was. Depressions were the reason or cause.

Regrettably also, the computer and all data present here were taken away by police. Electronic data, including my e-mail program, are protected – and I would never give the police the pass words (nor did I) - but the paper versions with data were not protected. One of the two members mentioned had deleted all data, the other intended to bring his paper versions here, but, regrettably again, he left the plastic bag with the papers in the train and we have never seen them again.

On December 1, 2003, I ended my sabbatical period and started to obtain all hardware and software again and to reconstruct all data, re-download the web sites, and so on. The financial report could be reconstructed and the money has been returned.

Now, in May 2004 I have again all the hardware, software and nearly all data needed. I was able to organize the Meeting, andmake a new Newsletter and first update of the web sites. The next Newsletter and update will follow after the Meeting.

Members

Ipce has now ninety members in eighteen countries all over the world. Sixty of them are reachable by e- mail. Some are unreachable due to the absence of a correct address. Thirty of them are connected on the protected internal electronic forum IMO, Ipce Meets Online.

Web sites

Ipce has two domain names, ipce.org & ipce.info, and a sub-domain: wanadoo.nl/ipce. The main Ipce web site, < http://www.ipce.org/ > is now hosted at < http://www.ipce.info/ipceweb/ >. Here are the home page, the registers and the main reference pages to articles. The register is by author – overviews according to subject will follow next year.

Due to lack of room, a second library has been opened at < http://home.wanadoo.nl/ipce/ >, where the longest files, PDF and ZIP files and the Newsletters are. Similarly, because of lack of room, a third library is at < http://www.ipce.info/library_3/ >. The three web sites are connected with a large number oflinks. The three web sites amount to more than 1000 files on 32.5 MB web room. The counter on ipce.info counts nearly 70.000 visitors since 22 July 2002, about 75 each day. The search engine on the home pages has about seven visitors each day.

Another web site is the IMO Forum and an archive, which is not public and only meant for internal communication. The kind of Forum and the URL has changed several times in the course of years. Since 25 November 2002, we have used a system on which more than 1000 messages have been exchanged.

I am able and willing to continue my tasks during the next year.
Frans"

The meeting accepts this report, and thus the policy behind it, thanks Frans, and appoints Frans to be the Secretary and webmaster during the next year.

b. Financial Report
May 1, 2003 - May 1, 2004

Starting balance	Euros ->	235,96
Income		
Contributions	527,30	
Gifts	1.196,60	
Other: rent	6,14	

Total income		1.730,04
Start + Income		1.966,00
Costs		
Newsletters	0,00	
Meeting	0,00	
Secretarial costs: Postbox & stamps	-131,65	
Website: provider	-392,70	
Web site: Other costs	-100,00	
Various costs	-26,03	
Total costs		-650,38
Final balance		1.315,62
ASN Account	619,36	
Postbank account	696,26	
Total		1.315,62
This report, the cash book and the bank accounts have been controlled by Titus Rivas, and found in good order.		

The meeting accepts this report, thanks the treasurer, and chooses Frans to be the treasurer during the next year.

c. Next Ipce Meeting

This meeting will be held at the end of May 2005 on one of the Greek isles.

Because travelling and hotels might be more or less expensive there, a vote was asked for this decision. The vote showed a majority for the decision.

d. *Ipce* discusses *Ipce*

The newly appointed secretary chose to pick up on a theme that had been discussed for a while on the previous day: What is *Ipce*, What is it not?

Introduction

As an introduction, he said, "I will mention that this is the 17th Ipce meeting. I want to call back in memory the meeting we had in 1998 in Athens. There were only a few members, but there have been made important, and supposedly wise, decisions: important changes in Ipce itself.

Before 1998, it was "IPCE", since 1998 it is "Ipce": name, historical name, no abbreviation. Before, Ipce was 'an association of associations'. People present were delegates from their organizations: they were not present as a person, but as a delegate. Since 1998, Ipce is a *Forum* for *persons*. Members present at the meetings are there as a person, not as a delegate. Members are persons, not organizations. Guests may be invited: as a person or as delegates.

Ipce is not an action group, it is only a Forum. As a Forum it undertakes no action, except making a Mission Statement and doing what is said in that statement: making and maintaining a web site, a Newsletter and an archive of texts (texts only, no images), exchanging documents and organizing meetings.

I know there are always people, especially young ones, who ask for "Action!". Nevertheless, Ipce keeps to be a Forum only. Action is to be taken by the members and their groups themselves.

Because Ipce is a Forum, there is not 'one and only true Ipce opinion': a forum allows a collection of opinions. Important opinions are collected on the web site in the chapter "Statements". These are not "Ipce Statements" in the meaning of: 'Ipce has voted about these texts', but only in the meaning of 'These statements, made by members, are felt as being shared by most other members'. Ipce does not vote about statements, except its Mission Statement.

BTW, Ipce is not a formally registered organization. In the Netherlands, there is a formal Register of Associations, Foundations and Companies, but Ipce is not registered in this way. The consequence is that Ipce cannot open a bank account with its name. Both bank accounts mentioned are set on the name of the treasurer and secretary. Also, the domain names and the provider accounts, are set on the name of the webmaster."

Discussion

As during every meeting, there was a proposal to change the name. However, the secretary referred to the argument at the Athens Meeting that said that the name Ipce is so well known all over the world, that it would not be wise to change it. As the webmaster, he added to it the argument that there are hundreds, maybe thousands of links everywhere on the Internet that refer to the "Ipce web site", and also hundreds of links within the three libraries of the Ipce web sites themselves. The name is too well known and used to be changed. BTW, if you type "ipce" in Google, you will see hundreds of links to organizations with more or less the same name. The "I" may stay for "International", the "P" for "Priests" or "People" or "Phone", the "C" for "Company" or "Christian", the "E" for "Electronics" or whatever. So, the meeting again decided not to change the name.

Indeed, as during every meeting, young people asked for more "Action!". However, a grey member said that this is not especially a difference between the generations, but a difference in opinion. If we undertake action as a group, we are as a group responsible for it. Being only a forum, we are not responsible for what the members do: they are responsible for their own actions, which is a far better basis on which to undertake any action. If we do not undertake action as a group, that is not a reason to avoid discussions about ideas and plans. The group might inspire its members, give ideas and criticism, and may inspire the members to help one another. If there are good ideas but no one picks them up, it is a pity, but that's up to the members themselves, and not a shame for the group.

Some members referred to other groups, like those in Berlin, who operate quite effectively without any formal registration or even members' lists. Informal groups can work quite effectively. Help can be better given from person to person, not as a member of one group to a member of another group.

Otherwise, to make such a Mission Statement as we have, to gather statements from members, to make a web site and a newsletter, and so on – to do such things is a kind of action – in fact, a political action with a political agenda. Inspiring the members is also a kind of action with an agenda.

Other members said they hate to be pressed into any action, or to be labelled with any opinion on what is voted. The way we are working now is a good way: it gives freedom as well as ideas and inspiration and courage. They said they appreciate feeling this freedom, inspiration and courage. The (young) members asking for *Action!* agreed with these views on Ipce and its policy.

Some members personalized the way Ipce works by pointing to Frans, saying words like: 'Ipce was dead if Frans did not exist and worked as he did'. They refer to the last year, in which his replacements appeared to have been unable to do anything. Frans should search for 'back-up persons' or substitutes, and search for trainees to learn this way of working with a great and

worldwide group like Ipce. It asks for much know-how, social skill to manage such a group without conflicts, and technical skill to manage the mail and the web sites.

Vorige | Start | Omhoog | Volgende

4. Discussion about Ethics

Paper for the 17th Ipce Meeting, 2004
By Frans Gieles

Intro

Several years ago, in Copenhagen (1993) and Amsterdam (1994), we discussed ethics. We developed four principles or guidelines. We took up the thread in Berlin (2001) and in Rotterdam (2002).

To refresh our memories:

These four guidelines or principles followed by a "PS" were, in a short, recently (i.e. after the discussion in Rotterdam 2002) revised version:

- **1. Self-determination:**
  Children must always have it in his or her own power to regulate their own intimacy, their relationships with others and their own lives.
- **2. Initiative:**
  Even in a later stage of the relationship, it is always the children who make the choice to initiate intimacy.
- **3. Freedom:**
  At any moment within the relationship with an adult, children must have the freedom to withdraw from the relationship. Love and dedication must be unconditional.
- **4. Openness:**
  The child should not have to carry unreasonable secrets. One has to take into consideration how the child lives with its own sexuality. This openness depends a great deal on the quality of the relationship, and the support from the adult(s).
- **P.S.:**
  The local mores and customs also play a role, as openness about children's intimate lives is not always appreciated. Children often must have any intimacy in secret. Homosexuality, for example, is for many youngsters a big taboo. This can bring many problems and insecurity. If the sub-culture in which they live is relaxed and strong enough, then children can find support in that environment

These four principles were seen as good in certain situations, but generally too limited and partly contradictory. The principles speak about avoiding a bad situation, but have no positive goal or fundamental expression of what is good. The principle of *openness, especially,* was seen

as a debatable one.

The idea in Berlin, 2001, was to maintain the four principles, but regard them as thoughts, not as rules, and to put them into a broader frame and add more thoughts as a frame around the principles. The Ipce Meeting in Rotterdam, 2002, has done this.

Using this approach, I have taken parts of the text of the report of that meeting and changed it from a report into a statement -- a proposal for an Ipce Statement. Tom gave a long lecture in Berlin, 2001. His ideas are embedded in the next text.

I propose to add two sentences to that text. They are here below given as [added >] blue text [< added]. The reason is that two other organizations, the Association Martijn and C-Logo have decided recently to take over 'our' guidelines, but in a somewhat different wording and order:

> "In relation to this physical intimacy, MARTIJN Association proposes four guidelines, namely:

1. Consent of both child and adult.
2. Openness towards the parents of the child.
3. Freedom for the child to withdraw from the relationship at any moment.
4. Harmony with the child's development."

By adding guidelines 2 and 4, we are more in harmony with those other organizations.

About ethics

The guidelines we give here are ideals to strive for. They are meant as *global* guidelines or principles. Nobody can give exact *rules* for every situation. The guidelines provide concepts to have in mind and to take into consideration. One should, however, still make a case-by-case judgment. The guidelines are more or less tied to an actual culture and era, hence not eternal. Ethics change in the course of time, in the course of the discourse.

Ethics are not plucked from the air. For us, there are two ethical sources:

- *human rights* and
- *reasonable thinking*.

Our ethics

Society *has* its rules and ethics about mutual relationships and intimacy between children or adolescents and adults. *Keep your distance* is the rule; fear of sexuality is its basis. In our vision,

this is not ethical. But we are also part of this society.

This double position, criticizing the society of which we are a part, results not only in our handing out sharp criticism, but also in formulating ethical principles that are acceptable to the same society.

The guidelines

Freedom of choice

In *any* intergenerational relationship or contact, both partners, the adult as well as the young person, should have it in their power to regulate their own lives, their relationships and the grade of intimacy.

Each partner has the right to self-determination and the responsibility to acknowledge this right in the other. Therefore, both partners in open communication will at any moment choose the grade of intimacy.

- In *friendship* relationships or contacts, both partners have the freedom to withdraw from the relationship at any moment. Love and dedication are unconditional; they bind partners who are free and independent.
- In *dependency* relationships or contacts, (such as parent-child or teacher-pupil) love and dedication should also be unconditional, but freedom to withdraw does not exist in practice. So, extra attention should be given to the right to self-determination and the responsibility of both partners. Here, the grade of intimacy has two limits: complete distance is not possible nor wanted, complete intimacy will interfere with the dependency: complete intimacy asks for complete freedom, which does not exist in dependency relationships, thus complete intimacy is not possible in these relationships.

The grade of openness

Openness is a typical western value; many other cultures have the value to respect and maintain secrets. Openness within a relationship is a good value. [Added >] Openness to the parents is strongly recommended. [< Added]

Openness to others is a good value as long as they respect one's right to self-determination. So, openness to others may be good, but it is not always necessary and not always possible. For example, intimacy between males is still a great taboo, as, for instance, in most schoolyards. Or, in many families, the very existence of any form of an intimate life of a young person is a taboo.

Many young people prefer consciously to have their own secrets. They make their own choices

and do not want to be protected. ‘Don’t treat me as a child’, they say. It is their right to have this freedom. The freedom to say *no* and the freedom to say *yes*. There is also a right of privacy.

The other side of the coin is that young people should not have to carry too heavy or unreasonable secrets. One has to take into consideration how the young person lives and how his environment may react.

Do no harm

[Added >] This includes acting in harmony with the development of the child. [< Added]

Harm can come from feelings of shame and dirtiness, learned from society. Harm can come from a society that uses power or violence to force the end of a relationship. One should consider this risk, as well as the risk of blackmail. The adult as well as the young person is vulnerable in this society nowadays. Thus: do no harm nor take the risk.

Discussion during the Meeting

This is a proposal for an Ipce statement, written by a member and discussed in the group. As is said in the section above:

> Because Ipce is a forum, there is not 'one and only true Ipce opinion': a forum allows a collection of opinions. Important opinions are collected on the web site in the chapter "Statements". These are not "Ipce Statements" in the meaning of: 'Ipce has voted about these texts', but only in the meaning of 'These statements, made by members, are felt as being shared by most other members'. Ipce does not vote about statements, except its Mission Statement.

"The earlier versions of our guidelines were more or less defensive," said a member. "This text is better and I can live with it. NAMBLA has had its position papers. These were very detailed and a bit legalistic. Such a statement is better: it is not the end of discussion or a law for ever. It is the state of mind we have now, the discussion can go on."

"Indeed," said another. "In Berlin and Rotterdam, we had long discussions, and this paper is still more or less subjective. The crucial point is the openness. Nowadays this is almost impossible. Many parents will forbid the relationship. If one views openness as a *conditio sine qua non*, intimacy is impossible or unethical - and a lot of members and others, like Martijn and CLogo, agree with this view, as Frans does. Others want to protect the relationship against such bans. However, if a relationship is secret but suddenly comes to the light and suddenly ends, this is also a disaster for all people concerned. Thus, taking openness as a condition is also protecting a relationship against this disaster.

Freedom and rights are OK, but with freedom and rights comes also responsibility - I mean for both the adult and the child. See the word "both" in the proposed text. If the young person wants to have secrets, as most teenagers do, this is also his or her right. In heterosexual relationships between teenagers, the same problem comes up. Openness can be important for pregnancy prevention. The doctors have the same problem: should they inform the parents, or accede to the wish for secrecy of the young ones?

For whom is this text written? For people with pedophilic feelings, and for the public. Some do not want to discuss the issue with the public. Others, Ipce members, Martijn and CLogo, explicitly want this and choose a text that might be a good point to start the discussion, thus a text that is acceptable, for example, to parents."

"This discussion," remarks a member, "has two levels. One is: will we make and present such a text? The other is: what will the content of that text be? Several members agree with making such a text. We want to offer our actual ideas to others; we need a starting point for the discussion. Our earlier texts on ethics have been adopted, for example, by some Dutch psychiatrists. NAMBLA has had long position papers. Martijn and CLogo, inspired by us, opted for four short statements. That will work better.

It would be important in an introduction, to explain the intention of this text: not as a series of legalistic rules, but as a set of ideas proposed in a discussion. Maybe it presents more an ideal than reality. The recommendation is "Take into your consideration ..."

It might be good to present examples: practical and realistic situation and an advise for such kind of situations. The New York Times Magazine has a column "The Ethicists" that regularly present moral dilemmas, situations introduced by the readers.

It might also be good to publish this statement in the Ipce Newsletter and to ask all members to agree or otherwise to react. In doing so, we really are a forum for exchange of thoughts.

Without a vote, the Meeting agreed with the placing of the proposed text, maybe in a next version, as a statement in the Newsletter and asking for reactions.

Vorige | Start | Omhoog | Volgende

5. Discussion about Depression

More and more, many people tell us they are depressive – and even, "horribly depressive". A lot of people tell me they don't read any newspaper, nor see any TV programme because they cannot cope with all the negative news.

What exactly is a depression?
How to prevent it?
How to cope with it?
How can you help depressive people? People planning suicide?
Literature? Theories?

Frustration belongs to life and has to be coped with. Compensation may help to cope with inevitable frustration. Frustration can lead to depression. Depression can be temporarily feeling blue or it may be a long lasting serious problem. In the case of the latter, it is an illness for which professional help and maybe medicines will be necessary. A characteristic of depression is to feel that one has an irresolvable problem and is in a situation that gives no chance of escape or hope.

What to do?

- The worst reaction is to stay passive and do nothing. But that's just what characterizes a severe depression. Thus, one has to (learn to) prevent that situation.
- Any change might be helpful: a break or a pause, or even small changes in the situation.
- Picking up even a tiny task and performing it completely can help.
  "If I have to cope with a sudden problem, I start with sweeping my floor and washing the dishes, putting my house in order, cooking a dinner, and so on. Then I take a long walk with my dog. So I let my hands and legs do the first part of the work. The mind will follow later on."
- The most effective help can come from friends: talking with them is the only thing that helps.
- To have friends to talk with, one should be a member of one or more groups. Groups are often able to bear and solve problems.
- Talking to a therapist might be an alternative. However, in some countries one cannot describe the real problem even to a therapist because the latter has the legal obligation to report to the police.

Frequently, people take a kind of self-medication against depression: alcohol or other drugs.

> "I have been in that situation, albeit a long time ago. You might suppress your depression by taking alcohol, but if you stop drinking, you will see that the world hasn't changed. So I did, and yet the depression came - and kept coming frequently, every three months.
> I consulted a doctor, and he said: 'It is not the world around you that causes the depression, but the way you cope with that world. You cannot change the world. The only thing you can change is yourself. Thus, you have to work with yourself.
> I started a kind of group programme similar to the AA. The group read a self-help manual and went through a kind of course or training. Still the depressions came and went, but ultimately they declined and disappeared. A self-help book about good ways of living (*Lebenskunst*) has especially helped me. Note, that you have to help yourself, but a group can be helpful to perform this."

Accepting medicines from a doctor is factually changing bad drugs for better ones. What these pills can do is only starting up a process that you have to complete yourself. Note that you yourself can start a depression by allowing yourself a lot of self-pity.

Depressions are not caused by messages in the newspapers, nor even by seeing TV shows like those of the German undercover reporter. Some people think that the media cause their depression and they refuse to read newspapers or watch TV news shows. But in that case, they are isolating themselves and stimulating their depression.

A depression comes from inside. Isolating your own feelings can especially initiate it. It is better to experience your feelings intensively, particularly if you feel anger. Let it come! And let that anger stimulate your fighting spirit. You should recognize your own painful feelings in good time, before they grow too much and may overwhelm you. Share your feelings with friends, and thus be a member of groups. Therefore, come out of your home. Isolating yourself makes your life meaningless. In a group, you cannot isolate yourself and you can express your feelings.

Indeed, said another member of the group, you need people; thus establish contacts; even short and neutral contacts may help. The best is to establish broad contact with enough people in several groups or roles.

To start the process of recovering, you need the positive experience of completing any task you are able to, even a simple one. Search through your abilities and *do* something. This can compensate for your feeling of frustration. If this is impossible, then you might need a doctor and some pills. Medication may diminish the strength of the earlier, overwhelming problem and make you able to make such a start by solving simple problems and achieving small changes in the situation, or doing other kinds of things. The crucial point is: *do* something, and do it *now*. Even in a clinic, this will be a start.

Even a 'small start' may break the vicious circle and may be enough to call up the recovering forces in yourself. Knowing that, we have, with some friends, cleaned someone's house and have put it in order. That was a start.

Sometimes, a confrontation may call up the recovering forces within someone. For others, creating some hope will help, even if this might be an illusion. But in some cases, cleaning the house and other rational ways will not help. In that case, changing the chemistry of the brain will be the only way.

Vorige Start Omhoog Volgende

6. Evaluation of the Meeting

"I was the one who reported my depression at the start of this meeting. Now, I feel better and even a bit optimistic. What we do has meaning, it is realistic and wise.
It was important to see each other, to speak with each other, even to be corrected.
I appreciate that there were no piles of papers or resolutions during this meeting: no votes but talks and encounters."

"This is my second Ipce Meeting. I learn a lot of things here that feed my artistic work. Ipce feeds me with information and ideas. Here are the people who can change society. Do not only look at the aggression of society, but also see yourself fighting against the same. Sharing this was incredibly encouraging for me."

"Nice to see most of you again, the regular customers in Ipce's meetings as well as new faces. Thanks to our hosts. I am content with this conference."

"I have mostly listened. I am not very good in discussing matters, but for me it was very interesting and inspiring."

"Thanks for inviting me to this meeting, it was my first Ipce meeting. I am glad to have met the people behind the names and messages. I have learnt new ideas and new perspectives."

"Also for me it was the first meeting. It was good and interesting. Thanks to our hosts and also thanks to Frans for his way of leading the discussions. Sometimes he had to keep one person or another in check. I will do what I can and hope to be present next year."

"For me, it is the fourth meeting. I appreciate the possibility to meet people and to exchange ideas. I still have hope: also bad experiences, as they were told from several countries, may lead to good things."

"Thanks to our hosts, yes. Young people here complained more or less 'nothing happens, we want action', but these meetings, most or all of which I have shared, create a context in which something can happen. I also thank Frans for his moderating the discussions - and moderating me now and then."

"My expectations have mostly come true: meeting people, gathering information and discussing practical strategies. More is not possible. It has inspired me. The discussions on the Internet, the papers here(at this Conference), and the encounters; this all works. Discussion asks for time, more time factually than we had. In that case, preparation and papers may be

helpful."

"I was pleased to meet you again. It gives me the feeling of 'you are not alone'. We are, in our group, active on the local and national level. Now I have heard about other countries. So, I enjoyed the possibility to make plans and create ideas. It was good to also speak about those depressions. I know what they are. Maybe I am too quickly frustrated if people promise things but do nothing. For myself, I always want to keep my word, and do what I have promised. But I know and have heard that depressions may hinder people from keeping their promises."

"This was my third meeting. Here, in Germany, we have had a difficult year. But I was glad to see and meet you here."

"My impression is good. It was my first meeting. My English is not very good to understand each detail. Thanks for translating now and then by several people. My priority is to work in my own city. For this work, I have acquired ideas."

"I was glad to be here. I am content about this meeting. Because of all the problems in my country and group, I had only short time for preparation, but encounter is more important than prepared papers. The meeting in Berlin was said to be very inspiring; the meeting in Rotterdam was said to be a bit boring, but now, the 17th Ipce Meeting, I hear again 'inspiring'. For me, the encounters are the most important, more, indeed, than papers and resolutions. I prefer discussion above votes and formal decisions. I prefer diversity of ideas. I am glad to see here grey hairs as well as young faces, regular visitors as well as new people. Thanks for the translations made during the meeting, thanks to our hosts.

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Psychiatric Association Debates Lifting Pedophilia Taboo

By Lawrence Morahan, CNSNews.com Senior Staff Writer
June 11, 2003

http://www.cnsnews.com/ViewCulture.asp?Page=%5CCulture%5Carchive%5C200306%5CCUL20030611c.html

In a step critics charge could result in decriminalizing sexual contact between adults and children, the American Psychiatric Association (APA) recently sponsored a symposium in which participants discussed the removal of pedophilia from an upcoming edition of the psychiatric manual of mental disorders.

Psychiatrists attending an annual APA convention May 19 in San Francisco proposed removing several long-recognized categories of mental illness - including pedophilia, exhibitionism, fetishism, transvestism, voyeurism and sadomasochism - from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Most of the mental illnesses being considered for removal are known as "paraphilias."

Psychiatrist Charles Moser of San Francisco's Institute for the Advanced Study of Human Sexuality and co-author Peggy Kleinplatz of the University of Ottawa presented conferees with a paper entitled "DSM-IV-TR and the Paraphilias: An Argument for Removal."

People whose sexual interests are atypical, culturally forbidden or religiously proscribed should not necessarily be labeled mentally ill, they argued. Different societies stigmatize different sexual behaviors, and since the existing research could not distinguish people with paraphilias from so-called "normophilics," there is no reason to diagnose paraphilics as either a distinct group or psychologically unhealthy, Moser and Kleinplatz stated.

Participants also debated gender-identity disorder, a condition in which a person feels discomfort with his or her biological sex. Homosexual activists have long argued that gender identity disorder should not be assumed to be abnormal.

> "The situation of the paraphilias at present parallels that of homosexuality in the early 1970s. Without the support or political astuteness of those who fought for the removal of homosexuality, the paraphilias continue to be listed in the DSM," Moser and Kleinplatz wrote.

A. Dean Byrd, vice president of the National Association for Research and Therapy of

Homosexuality (NARTH) and a clinical professor of medicine at the University of Utah, condemned the debate. Taking the paraphilias out of the DSM without research would have negative consequences, he said.

> "What this does, in essence, is it has a chilling effect on research," Byrd said. "That is, once you declassify it, there's no reason to continue studying it. What we know is that the paraphilias really impair interpersonal sexual behavior...and to suggest that it could be 'normalized' simply takes away from the science, but more importantly, has a chilling effect on research."

"Normalizing" pedophilia would have enormous implications, especially since civil laws closely follow the scientific community on social-moral matters, said Linda Ames Nicolosi, NARTH publications director.

> "If pedophilia is deemed normal by psychiatrists, then how can it remain illegal?" Nicolosi asked. "It will be a tough fight to prove in the courts that it should still be against the law."

In previous articles, psychiatrists have argued that there is little or no proof that sex with adults is necessarily harmful to minors. Indeed, they have argued that many sexually molested children later look back on their experience as positive, Nicolosi said.

> "And other psychiatrists have written, again in scientific journals, that if children can be forced to go to church, why should 'consent' be the defining moral issue when it comes to sex?" she said.

But whether pedophilia should be judged "normal and healthy" is as much a moral question as a scientific one, according to Nicolosi.

> "The courts are so afraid of 'legislating someone's privately held religious beliefs' that if pedophilia is normalized, we will be hard put to defend the retention of laws against child molestation," Nicolosi noted.

In a fact sheet on pedophilia, the APA calls the behavior "criminal and immoral."

> "An adult who engages in sexual activity with a child is performing a criminal and immoral act that never can be considered normal or socially acceptable behavior," the APA said.

However, the APA failed to address whether it considers a person with a pedophile orientation to have a mental disorder.

> "That is the question that is being actively debated at this time within the APA, and that is the question they have not answered when they respond that such relationships are 'immoral and illegal,'" Nicolosi said.

Dr. Darrel A. Regier, director of research for the APA, said there were

> "no plans and there is no process set up that would lead to the removal of the paraphilias from their consideration as legitimate mental disorders."

Some years ago, the APA considered the question of whether a person who had such attractions but did not act on them should still be labeled with a disorder.

> "We clarified in the DSM-IV-TR...that if a person acted on those urges, we considered it a disorder," Regier said.

Dr. Robert Spitzer, author of a study on change of sexual orientation that he presented at the 2001 APA convention, took part in the symposium in San Francisco in May.

Spitzer said the debate on removing gender identity disorder from the DSM was generated by people in the homosexual activist community "who are troubled by gender identity disorder in particular." Spitzer added: "I happen to think that's a big mistake."

What Spitzer considered the most outrageous proposal, to get rid of the paraphilias, "doesn't have the same support that the gender-identity rethinking does." And he said he considers it unlikely that changes would be made regarding the paraphilias.

> "Getting rid of the paraphilias, which would mean getting rid of pedophilia, that would not happen in a million years. I think there might be some compromise about gender-identity disorder," he said.

Dr. Frederick Berlin, founder of the Sexual Disorders Clinic at the Johns Hopkins Hospital, said people who are sexually attracted to children should learn not to feel ashamed of their condition.

> "I have no problem accepting the fact that someone, through no fault of his own, is attracted to children. But certainly, such an individual has a responsibility...not to act on it," Berlin said.
> "Many of these people need help in not acting on these very intense desires in the same way that a drug addict or alcoholic may need help. Again, we don't for the most part blame someone these days for their alcoholism; we don't see it simply as a moral weakness," he added.
> "We do believe that these people have a disease or a disorder, but we also recognize that in having it that it impairs their function, that it causes them suffering that they need to turn for help," Berlin said.

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Online Sex Abuse Cases Not Characterized by Deception, Abduction and Force, Research Shows

Findings From National Sample of Law Enforcement Agencies Indicates That Current Prevention Efforts Emphasizing On-Line Deception May Be Missing Their Mark

Kimberly Mitchell, Ph.D.,
Janis Wolak, M.A., J.D. &
David Finkelhor, Ph.D.,
APA.
August 1, 2004

Full text at < http://www.apa.org/releases/online_sexabuse.html >

Warnings about Internet child molesters often depict them as predators who impersonate peers to befriend children and lure them into encounters that end in abduction, rape and murder. But a new study of a national sample of such cases from U.S. law enforcement agencies paints a different and disconcerting picture of the dynamics involved in these crimes.

According to the study:

- Most offenders did not deceive victims about the fact that they were adults interested in sexual relationships
- The victims, primarily teens aged 13 to 15, met and had sex with the adults on more than one occasion
- Half of the victims were described as being in love with or feeling close bonds with the offenders
- Few offenders abducted or used force to sexually abuse their victims.

These findings suggest the need for parents, educators and the media to revise their approaches to preventing Internet sex crimes, according to the authors of the research, Janis Wolak, M.A., J.D., David Finkelhor, Ph.D., and Kimberly Mitchell, Ph.D., of the Crimes against Children Research Center at the University of New Hampshire. Dr. Mitchell will present their findings at the 112th Annual Convention of the American Psychological Association (APA) in Honolulu.

The researchers surveyed local, state and federal law enforcement investigators from 2,574 law

enforcement agencies between 2001 and 2002, to identify sexual offenses against juvenile victims that originated with an online encounter and ended with the arrest of an offender.

Findings show

- that despite the stereotypes of Internet sex crimes against minors, offenders targeted adolescents, not younger children
  (99% were age 13 to 17 and none were younger than 12).
- Only 5% of offenders tried to deceive victims about being older adults.
- Only 21% lied about their sexual motives, and most of these deceptions involved insincere promises of love and romance.
- Few offenders used
  - force (5%) or
  - coercion (16%) or
  - abduction (3%)
    to sexually abuse their victims.
- The research also suggests that it may be misleading to categorize offenders in such cases as strangers, because victims and offenders had typically communicated, both online and by telephone, for more than one month prior to meeting in person.

According to the authors, the study has several implications for prevention. Rather than emphasize the dangers of deception,

> "the data suggests that a major challenge for prevention is the population of young teens who are willing to enter into voluntary sexual relationships with adults whom they meet online. This is a reality that people may be reluctant to confront, but effective prevention requires public and private acknowledgment of what actually happens in these cases," according to the researchers.

They add that teenagers may benefit from being told directly about why such relationships are a bad idea and made to understand that adults who care about their well-being would not propose sexual relationships or involve them in risky encounters.

The authors also urge prevention efforts to focus special attention on the most vulnerable populations for Internet-initiated sex crimes against minors. These include

- adolescents who have poor relationships with their parents,
- those who are lonely or
- depressed, or
- gay teenagers or

- those questioning their sexual orientation who turn to others on the Internet for support or information.

The authors also recommend training for law enforcement since some of the targeted youth may not initially see themselves as victims and may require sensitive interviewing in order to cooperate with investigators.

The research was funded jointly by the National Center on Missing and Exploited Children and the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, and will be published online in the November issue of the Journal of Adolescent Health.

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Extreme sentences demanded, mild court

By JON

As has been told in the Newsletters 16 & 17, members of the group JON had to face a lot of problems: arrests and house raids. All arrested people had travelled to Tunisia last summer. Anyone who had asked to see the photo's of that trip has had his house raided, but also anyone who seemed to be a leader of the group. In June there have been court sessions with some remarkable facts.

One of the charges was the membership of a criminal organization with the aim to abuse children and to produce child pornography. In every session the court asked the prosecutor to which organization she referred: was it the group JON? In every session the prosecutor said "No sir, only some individuals, not that group."

Remarkably enough, there were no charges about behavior in Tunisia. In the Netherlands, making a confession is not enough for a conviction. Supporting evidence is needed for it. There was no supporting evidence because the Dutch police was not allowed to enter Tunisia to gather evidence or reports.

What remained were charges concerning the possession or spreading of child pornography and in some cases child sexual abuse that was confessed, reported and investigated. Also, in some cases, hiding illegal material to keep it out of hands of the police.

In this kind of cases, it is routine to establish social, psychological and psychiatric investigation and to ask those experts to advise the court. It is also routine to declare anyone who has even paedophilic feelings to be mentally distorted, to be a risk for recidivism, and to be in need of treatment. So was done in all cases.

De sentences demanded by the prosecutor were, for the Netherlands, extreme: six to eight years prison and in all cases forced treatment in a closed clinic by the state.

The court was very critical to the prosecutor. In one case, the prosecutor handed over a set of photos saying it was child pornography. The court had a look at the photos and said: "I do not see any child pornography here" and declared the accused to be free the next day.

A fortnight later, the court gave its judgment, which was remarkably milder than the prosecutor's demands: from eight months to three years and only in one case forced treatment. The membership of a criminal organization was judged as not proven: the appointments for the

trips to Tunisia were holyday appointments between individuals, not an organization. Those who had got the lowest sentences are already free now.

Remarkably enough, the Dutch press and TV had mentioned the high demands of the prosecutor, to say so, in capitals, but mostly has not mentioned the far milder judgement at all.

However, the prosecutor has appealed to a higher court in all cases. The story will go on. The next chapter has already started, because the prosecutor demanded that the accused had to wait for the appeal sessions in prison, even if they could be freed according to the judgment of the first court. The higher court decided to follow that judgment and to let them free. The higher court sessions will be in December.

In the meantime, the group JON goes on, has its talking sessions. We have made a kind of behavior protocol or code for the members to avoid such kind of problems in the future.

Vorige Start Omhoog Volgende

MARTIJN present at the Belgian Lesbian and Gay Pride

MARTIJN Association at the BLGP MARTIJN Association, a platform for discussion about pedophilia, is present at the BLGP (Belgian Lesbian and Gay Pride) to plead for the emancipation of pedophiles.

Pedophilia is a preference. Pedophiles feel mainly attracted, including sexually, to prepubescent children of either or both sexes. This attraction does not imply an action. It is no abuse of or 'sex with' children. It is neither an extreme urge against which resistance is impossible.

Most child rapists are absolutely no pedophiles, but situational molesters, usually heterophiles. The other way around, by far most pedophiles are no rapists.

Freddy Thielemans, mayor of Brussels City, writes in his invitation to the BLGP that each human being has a right to respect and esteem. We hope that for him the same goes for pedophiles who give shape to their feelings in a befitting manner. The BLGP organization puts on its website (www.blgp.be) in its "list of demands 2004" that gay and lesbian people support the fight against each form of discrimination on the basis of e.g. age and sexual orientation. We hope they thereby also think of pedophiles (and of children).

Demonization

The way in which politics deals with the subject "pedophilia" and the one-sided coverage in the media lead to demonization of all pedophiles. For most pedophiles it is terribly painful to read press reports with headlines such as: "Pedophile rapes child". Not only because of what has happened, but also because all pedophiles get bad credit. Press reports never contain headlines such as: "Heterophile rapes woman".

Once again: most child rapists are absolutely no pedophiles, but situational molesters, usually heterophiles. The other way around, by far most pedophiles are no rapists.

Manneken Pis

Today, Manneken Pis, the emblem of Brussels, wears a Pride-costume of designer Jonathan Bernard. Manneken Pis is a small bronze statue that serves as a fountain, but... it is also a nude little boy. This makes one think. We want to present you with a question:

Is it always undesirable for children to experience physical pleasure?

What we stand for

MARTIJN Association, founded in 1982, is a platform for discussion about pedophilia. MARTIJN Association fights for the social and societal acceptance of child-adult relationships. In relationships between children and adults that are experienced as pleasant, possible physical intimacy should not have to be a problem. In relation to this physical intimacy, MARTIJN Association proposes four guidelines, namely:

- Consent of both child and adult.
- Openness towards the parents of the child.
- Freedom for the child to withdraw from the relationship at any moment.
- Harmony with the child's development.

MARTIJN Association is for the objective, scientifically verifiable truth and against political terror and discrimination. It is a platform for everyone who wants to offer a counterbalance to the dogma that children and youngsters are harmed by friendships and loving intimacy with older persons.

The text of this flyer is also available on-line, at:
http://www.martijn.org/info/Pride_EN_2004.html

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Vorige Start Omhoog

The Moralist

Not since Lolita has a book so boldly explored intergenerational eros. Rod Downey's provocative new novel The Moralist is a literary nuclear device that explodes at ground zero of our most deeply held beliefs.

The plot is torn from the headlines of the child abuse witch-hunt gripping America today. It tells the story of a 50-year-old man and his 13-year-old student. As a communications "spin doctor," Red Rover advises boy-love activists how to survive in an environment of hostile press and fire-breathing hysterics. As he pursues the boy, he becomes increasingly outraged by the injustices that demonize a love that for Red is the very definition of beauty.

Red's own moral development and improbable life story serve as a springboard for a radical ethical and aesthetic perspective that corrodes conventional notions of moral principle.

For all its anger and profundity, the touch of THE MORALIST is light and humorous. In an epigrammatic, ironic style, Downey dances through sophisticated thickets of ethical philosophy and literary allusion with a wink and a grin. But make no mistake; THE MORALIST is in deadly earnest.

Whether you love Red Rover or hate him, one thing's for sure: You'll not forget him.

"…this voice needs to be heard in these new dark ages for civil liberties." —Frontiers Newsmagazine

"Read it if you dare. THE MORALIST is brilliant and outrageous. It is about things that matter: art, philosophy, politics, science, religion. Above all, it is a love story, and one like no other. But be warned: Your settled notions of right and proper conduct could be blown sky high by this controversial oeuvre." —Tom O'Carroll, author, Pedophilia: The Radical Case.

THE MORALIST by Rod Downey
392 pages, paper #19.95 U.S., $26.00 CAN.
ISBN: 1-887650-40-7
Order from FACTOR PRESS, P.O. Box 222, Salisbury MD 21803
(410) 334-6111 factorpress@earthlink.net

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Documentation List June - August 2004

An @ means that the document is electronically available at
webmaster@ipce.info

04-049 @ PDF 619 Kb	Campo de Criptana, Heft 4-1, Quartal 2004. Themen: u.a. Pädophilie, Peter Pan, die verlorenen Jungen und die verlorene Liebe.
04-50a & b @ PDF 51 Kb	a. McClure goes to jail b. McClure leaves jail McClure is a famous prosecutor, who a.o. has spread the next flyer in 1983:
04-051 @ PDF 94 Kb	Crack the Boy, flyer, 1983.
04-052 @ 5 Kb	Sharpe sentenced to two years; Canadian Press - Globeandmail.com, 19 July 2004 Vancouver — The man who challenged child porn laws in Canada's highest court was sentenced Monday to two years less a day for indecent assault. John Robin Sharpe showed no emotion as he was sentenced by Justice Robert Edwards. “There will be an appeal,” he said as he was led out of B.C. Supreme Court.
04-053 @ 106 Kb	New & Comment [on Law C-20, Canada:] What's happening with our child porn laws? By Robin Sharpe, Dec. 2003. Bill C-20 is an attempt to close any conceivable “loophole” in the adult / youth sex and child pornography laws. The adult / youth provisions are an attempt to effectively raise the age of consent to eighteen, something Ottawa did not do explicitly because of reservations by the Province of Quebec which did not want youth sex to be criminalized. The child porn provisions are a direct response to my acquittal [...]
04-054a @ 5 Kb	Stefan-Text aus dem PRD ist legal und jugendfrei
04-054b @ 27 Kb	The Stephan text from the PRD is now officially declared legal and not dangerous for youth.

04-055a @ 5 Kb	Compulsory lie tests for paedophiles, by David Cracknell, Sunday Times 04-08-01 PLANS by David Blunkett to introduce controversial laws forcing sex offenders to undergo lie detector tests are threatening to provoke a cabinet rift, leaked documents have revealed.
04-055b @ 7 Kb	Liberty supports preventive lie tests, by Alan Travis, The Guardian 04-05-29 Civil liberty campaigners said last night they would raise no fundamental objections to plans to introduce compulsory lie detector tests and satellite tracking of sex offenders in Britain.
04-055c @ 5 Kb	When the detector lies: why polygraph use will be restricted, by Sandra Laville, The Guardian 04-05-29
04-056 @ PDF 30 Kb	'Whispering keyboards' could be next attack trend, by Niall MacKay, SearchSecurity.com, 11 May 2004. Eavesdroppers scan decipher what is typed by simply listening to the sound of a keystroke, according to a scientist at this week's IEEE Symposium of Security and Privacy in Oakland, Calif., USA.
04-057a @ 5 Kb	The website of the Danish Pedophile Association re-emerges - the association itself remains closed, by DPA Gruppe 04, 18th of April 2004.
04-057b @ 16 Kb	What really happened; by Alex on 2004-April-23, posted on a Forum. Hi everybody, I'm a guy from the DPA (both the old and the new). I think it's time for some explanations.
04-058 @ 8 Kb	Catherine the HoloKitty's Page < http://www.asstr.org/files/Authors/holokittynx/www/ > Hi! I'm Catherine N.X., the HoloKitty. I'm a 19-year-old computer animation student in Los Angeles, California. [...] and I consider it cruel to treat any person's sexual needs as dirty or deviant. The only wrong is in harming another person or violating their trust. When I was younger, my mother began to teach me about sexuality and my own in particular.
04-059 @ 89 Kb	Zoophilia in men: a study of sexual interest in animals, by Martin S. Weinberg & Colin J. Williams, Archives of Sexual Behavior, Dec. 2003.
04-060 @ 40 Kb	False Allegations of Child Abuse; http://www.pathguy.com/abuse.htm The system is imperfect, and occasionally an innocent person is accused on bad medical evidence. Once the initial error is made, it is very hard to stop the process.
04-061 @ 8 Kb	How Did Gender and Class Shape the Age of Consent Campaign Within the Social Purity Movement, 1886-1914? http://womhist.binghamton.edu/aoc/doclist.htm

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Culture

Psychiatric Association Debates Reclassifying Pedophilia

By Lawrence Morahan
CNSNews.com Senior Staff Writer
June 11, 2003

Editor's Note: Removes 1st Add at the request of one of the report's authors.

(CNSNews.com) - In a step critics charge could result in decriminalizing sexual contact between adults and children, the American Psychiatric Association (APA) recently sponsored a symposium in which participants discussed the removal of pedophilia from an upcoming edition of the psychiatric manual of mental disorders.

Some mental health professionals attending an annual APA convention May 19 in San Francisco proposed removing several long-recognized categories of mental illness - including pedophilia, exhibitionism, fetishism, transvestism, voyeurism and sadomasochism - from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Most of the mental illnesses being considered for removal are known as "paraphilias."

Dr. Charles Moser of San Francisco's Institute for the Advanced Study of Human Sexuality and co-author Peggy Kleinplatz of the University of Ottawa presented conferees with a paper entitled "DSM-IV-TR and the Paraphilias: An Argument for Removal."

People whose sexual interests are atypical, culturally forbidden or religiously proscribed should not necessarily be labeled mentally ill, they argued.

Different societies stigmatize different sexual behaviors, and since the existing research could not distinguish people with paraphilias from so-called "normophilics," there is no reason to diagnose paraphilics as either a distinct group or psychologically unhealthy, Moser and Kleinplatz stated.

Participants also debated gender-identity disorder, a condition in which a person feels discomfort with his or her biological sex. Homosexual activists have long argued that gender identity disorder should not be assumed to be abnormal.

"The situation of the paraphilias at present parallels that of homosexuality in the early 1970s. Without the support or political astuteness of those who fought for the removal of homosexuality, the paraphilias continue to be listed in the DSM," Moser and Kleinplatz wrote.

A. Dean Byrd, vice president of the National Association for Research and

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Therapy of Homosexuality (NARTH) and a clinical professor of medicine at the University of Utah, condemned the debate. Taking the paraphilias out of the DSM without research would have negative consequences, he said.

"What this does, in essence, is it has a chilling effect on research," Byrd said. "That is, once you declassify it, there's no reason to continue studying it. What we know is that the paraphilias really impair interpersonal sexual behavior...and to suggest that it could be 'normalized' simply takes away from the science, but more importantly, has a chilling effect on research."

"Normalizing" pedophilia would have enormous implications, especially since civil laws closely follow the scientific community on social-moral matters, said Linda Ames Nicolosi, NARTH publications director.

"If pedophilia is deemed normal by psychiatrists, then how can it remain illegal?" Nicolosi asked. "It will be a tough fight to prove in the courts that it should still be against the law."

In previous articles, some mental health professionals have argued that there is little or no proof that sex with adults is necessarily harmful to minors. Indeed, some have argued that many sexually molested children later look back on their experience as positive, Nicolosi said.

"And other psychiatrists have written, again in scientific journals, that if children can be forced to go to church, why should 'consent' be the defining moral issue when it comes to sex?" Nicolosi said.

But whether pedophilia should be judged "normal and healthy" is as much a moral question as a scientific one, according to Nicolosi.

"The courts are so afraid of 'legislating someone's privately held religious beliefs' that if pedophilia is normalized, we will be hard put to defend the retention of laws against child molestation," Nicolosi noted.

In a fact sheet on pedophilia, the APA calls the behavior "criminal and immoral."

"An adult who engages in sexual activity with a child is performing a criminal and immoral act that never can be considered normal or socially acceptable behavior," the APA said.

However, the APA failed to address whether it considers a person with a pedophile orientation to have a mental disorder.

"That is the question that is being actively debated at this time within the APA, and that is the question they have not answered when they respond that such relationships are 'immoral and illegal,'" Nicolosi said.

Dr. Darrel A. Regier, director of research for the APA, said there were "no plans and there is no process set up that would lead to the removal of the paraphilias from their consideration as legitimate mental disorders."

Some years ago, the APA considered the question of whether a person who had such attractions but did not act on them should still be labeled with a disorder.

"We clarified in the DSM-IV-TR...that if a person *acted* on those urges, we considered it a disorder," Regier said.

Dr. Robert Spitzer, author of a study on change of sexual orientation that he

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presented at the 2001 APA convention, took part in the symposium in San Francisco in May.

Spitzer said the debate on removing gender identity disorder from the DSM was generated by people in the homosexual activist community "who are troubled by gender identity disorder in particular."

Spitzer added: "I happen to think that's a big mistake."

What Spitzer considered the most outrageous proposal, to get rid of the paraphilias, "doesn't have the same support that the gender-identity rethinking does." And he said he considers it unlikely that changes would be made regarding the paraphilias.

"Getting rid of the paraphilias, which would mean getting rid of pedophilia, that would not happen in a million years. I think there might be some compromise about gender-identity disorder," he said.

Dr. Frederick Berlin, founder of the Sexual Disorders Clinic at the Johns Hopkins Hospital, said people who are sexually attracted to children should learn not to feel ashamed of their condition.

"I have no problem accepting the fact that someone, through no fault of his own, is attracted to children. But certainly, such an individual has a responsibility...not to act on it," Berlin said.

"Many of these people need help in not acting on these very intense desires in the same way that a drug addict or alcoholic may need help. Again, we don't for the most part blame someone these days for their alcoholism; we don't see it simply as a moral weakness," he added.

"We do believe that these people have a disease or a disorder, but we also recognize that in having it that it impairs their function, that it causes them suffering that they need to turn for help," Berlin said.

E-mail a news tip to Lawrence Morahan.

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[To Articles & Essays - M]

Report to American Psychiatric Association

The following is **an extract of** a report presented at a May 19, 2003, symposium sponsored by the American Psychiatric Association entitled
"DSM-IV-TR and the Paraphilias: An Argument for Removal."

The report can be downloaded as a PDF file from
< http://home.netcom.com/~docx2/mk.html >

DSM-IV-TR and the Paraphilias: An Argument for Removal

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San Francisco, California

Peggy J. Kleinplatz
University of Ottawa
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Abstract

The DSM-IV-TR (2000) sets its own standards for inclusion of diagnoses and for changes in its text. The Paraphilia section is analyzed from the perspective of how well the DSM meets those standards. The concept of Paraphilias as psychopathology was analyzed and assessed critically to determine if it meets the definition of a mental disorder presented in the DSM; it does not.

The Paraphilia diagnostic category was critiqued for logic, consistency, clarity and whether it constitutes a distinct mental disorder. The DSM presents "facts" to substantiate various points made in the text. The veracity of these "facts" was scrutinized.

Little evidence was found in their support. Problems with the tradition of equating particular sexual interests with psychopathology were highlighted. It was concluded that the Paraphilia section is so severely flawed that its removal from the DSM is advocated.

DSM-IV-TR and the Paraphilias: Reevaluating an obsolete category

All societies attempt to control the sexual behavior of their members. One mechanism of

exercising this control is to define a specific sexual interest as pathognomonic for a mental disorder. Historically and cross-culturally, even an accusation of interest in specific sexual practices could result in death, imprisonment, loss of civil rights and other social sanctions. Similarly, being classified as mentally ill could result in death, imprisonment, loss of civil rights and other social sanctions. Thus, the confounding of mental illness with unusual sexual desires is understandable.

Which sexual interests are proscribed often changes; masturbation, oral sex, anal sex and homosexuality were once considered mental disorders or symptoms of other mental disorders but are now typically accepted as part of the spectrum of healthy sexual expression. Similarly, there are conditions that were accepted as "normal" in the past but are now classified as mental disorders (e.g., hypoactive sexual desire, sexual aversion disorder and female orgasmic disorder). It is exceedingly difficult to eliminate historical and cultural factors from the assessment of unusual sexual interests. As such, empirically based, scientific definitions of healthy and pathological sexual behavior continue to elude us.

Cross-culturally, sexual activity considered "acceptable" in the United States is viewed as "stigmatized" in other cultures; similarly, sexual activity considered "acceptable" in the United States is "stigmatized" in other cultures. For example, non-marital coitus is accepted in the U.S. but is stigmatized harshly in many Moslem countries; topless sunbathing among women at public beaches is accepted in Western Europe but illegal and condemned in most of the United States. Violation of these cultural norms often results in strong negative reactions. Given the socio-cultural context in which such beliefs are embedded, it is not surprising that the lay public and even many sex experts cannot understand how unusual sexual interests can signify anything but mental disorders. Nevertheless, it is the assumption that unusual sexual interests constitute symptoms of or are mental disorders *per se*, that we are questioning.

The American Psychiatric Association (APA) publishes the Diagnostic and Statistical Manual (DSM); it describes the diagnostic criteria and defining features of all formally recognized mental disorders. It serves as a definitive resource for mental health professionals. Although its primary influence is in the United States, its impact is global. A psychiatric diagnosis is more than shorthand to facilitate communication among professionals or to standardize research parameters. Psychiatric diagnoses affect child custody decisions, self-esteem, whether individuals are hired or fired, receive security clearances or have other rights and privileges curtailed. Criminals may find that their sentences are either mitigated or enhanced as a direct result of their diagnoses. The equating of unusual sexual interests with psychiatric diagnoses has been used to justify the oppression of sexual minorities and to serve political agendas. A review of this area is not only a scientific issue, but also a human rights issue. The power and impact of the DSM should not be underestimated.

The DSM is revised at regular intervals. Diagnoses can be added or eliminated and diagnostic criteria reformulated with each new edition. There have been six editions to date (APA, 1952, 1968, 1980, 1987, 1994, 2000). The current edition is designated DSM-IV-TR (APA, 2000) and

will be the focus of this paper.

With the publication of DSM-III in 1980, the focus of the DSM changed from a theoretically based, psychoanalytic model of illness to an evidence-based and descriptive model. The DSM is currently intended "[...] to be neutral with respect to theories of etiology" (APA, 2000, p. xxvi), based on objective observation and able to support its statements with empirical research. With this transition, the nomenclature of these disorders changed from "Sexual deviation" to "Paraphilia," a supposedly atheoretical, non-pejorative descriptor.

In the text of the latest edition of the DSM, it is asserted that a "comprehensive and systematic" (APA, 2000, p. xxvi) review of the literature was conducted in preparation of the DSM.

> "The utility and credibility of the DSM-IV require that it [...] be supported by an extensive empirical foundation" (APA, 2000, p. xxiii).

The text indicates,

> "...the majority of paragraphs in the DSM-IV have not been revised, indicating that, even after the literature review, most of the information in the original text remains up-to-date" (APA, 2000, p. 829).

Our own, extensive review found no literature to support most of the assertions made in the Paraphilia section of the DSM, and several studies were found that contradict the text (discussed below). Objective data to support the classification of the Paraphilias as mental disorders is lacking.

When the APA removed homosexuality from the DSM approximately 30 years ago, some observers thought that the other Paraphilias would also be removed from subsequent editions. The argument for removal of homosexuality was bolstered by the lack of objective research supporting its inclusion and research that failed to support the theory that homosexuals fit specific psychiatric stereotypes.

Nevertheless, some observers believe the removal of homosexuality was primarily a political act (Bayer, 1981). The situation of the Paraphilias at present parallels that of homosexuality in the early 1970s. Without the support or political astuteness of those who fought for the removal of homosexuality, the Paraphilias continue to be listed in the DSM.

The term "paraphilia" will be employed here in keeping with its use in the literature, even though we have serious reservations about the validity of the diagnosis and the applicability of this term. The rationale for the inclusion of the Paraphilia diagnostic category as it is constituted in the DSM-IV-TR (APA, 2000) will be addressed and challenged. It will be suggested that the construct of the Paraphilias is ambiguous and does not describe a

diagnosable, distinct mental disorder. A review of the scientific literature does not support the inclusion of this diagnostic category in the DSM.

Are the Paraphilias Mental Disorders?

The concept that unconventional sexual interests are mental illnesses or crimes (religious or societal) predates both the DSM and modern psychiatry. Sanctions against individuals who engage in proscribed sexual behavior have changed over time. At first, it was considered a sin to be governed by penitentials and religious courts. Over time, civil laws were used to "control" the unacceptable behavior. In the [past], the medical model was applied to transform these "sins" or "crimes" into "pathology"

> (Bullough & Bullough, 1977).

The assumption that Paraphilias are a form of psychopathology has been questioned, and each subsequent edition has attempted to address some of the perceived weaknesses in this diagnostic category. Nevertheless, the bulk of serious criticism

> (Davis, 1996; McConaghy, 1999; Rubin, 1992; Silverstein, 1984; Suppe, 1984)

has not been addressed fully.

In the DSM, it is indicated that it is difficult to define a mental disorder as well as mental health. Nonetheless, the text defines a mental disorder as being

> "...associated with present distress [...] or disability [...] or significantly increased risk of suffering death, pain, disability or an important loss of freedom" (APA, 2000, p. xxxi).

Individuals who engage in many common activities (scuba divers, gun owners, mountain climbers, inhabitants of many large cities and criminals) also incur increased risks of death, pain, disability, or loss of freedom but are not diagnosed with mental disorders. This apparent contradiction demonstrates that social context can affect the application of this definition.

To clarify the definition, the DSM further states,

> "Neither deviant behavior (e.g., political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above" (p. xxxi).

There is concern that psychiatric diagnoses can be used inappropriately to discredit dissenters;

at least in some venues, criminals have more rights and credibility than psychiatric patients do. The above statement was added to protect the labeling of unpopular or illegal activities as mental illnesses, but the last clause allows the clinician to disregard this distinction.

The DSM does not define healthy sexuality, much less healthy mood, thoughts or personalities. Unfortunately, the range of "healthy" human sexual behavior is not known, thus creating potential pitfalls in the diagnostic process. The DSM is meant to be interpreted by an experienced and objective clinician. Without consensus from the scientific literature, however, clinicians are often forced to rely on their own subjective evaluations.

The problem here is that engaging in "Paraphilic" behavior qualifies the participant a priori as a candidate for diagnosis. In addition, when individuals have unusual sexual interests, there is often speculation that any presenting problems are related to their sexuality. When a behavior *per se* signifies a diagnosis, then by definition the behavior is symptomatic of the disorder. This confound obscures the possibility that for at least some individuals, their specific sexual behaviors are healthy expressions of sexuality and beneficial to them. The fact that specific sexual behaviors are socially unacceptable or illegal is, and should be, irrelevant to the diagnostic process.

Historically, this was the situation that confronted homosexuals. When homosexual patients presented to a psychotherapist with any problem, it was often assumed that the problem was caused or exacerbated by their homosexual interests.

Cfr the discussion in Archives of Sexual behavior in

Gieles, F.E.J., Is pedophilia a mental disorder?
Discussion in *Archives of Sexual Behavior*; Report
The December 2002 issue is a special about pedophilia.

Read about the discussion within APA & its Statement

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Date: August 1, 2004
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ONLINE SEX ABUSE CASES NOT CHARACTERIZED BY DECEPTION, ABDUCTION AND FORCE, RESEARCH SHOWS

Findings From National Sample of Law Enforcement Agencies Indicates That Current Prevention Efforts Emphasizing On-Line Deception May Be Missing Their Mark

HONOLULU — Warnings about Internet child molesters often depict them as predators who impersonate peers to befriend children and lure them into encounters that end in abduction, rape and murder. But a new study of a national sample of such cases from U.S. law enforcement agencies paints a different and disconcerting picture of the dynamics involved in these crimes.

According to the study:

- Most offenders did not deceive victims about the fact that they were adults interested in sexual relationships
- The victims, primarily teens aged 13 to 15, met and had sex with the adults on more than one occasion
- Half of the victims were described as being in love with or feeling close bonds with the offenders
- Few offenders abducted or used force to sexually abuse their victims.

These findings suggest the need for parents, educators and the media to revise their approaches to preventing Internet sex crimes, according to the authors of the research, Janis Wolak, M.A., J.D., David Finkelhor, Ph.D., and Kimberly Mitchell, Ph.D., of the Crimes against Children Research Center at the University of New Hampshire. Dr. Mitchell will present their findings at the 112th Annual Convention of the American Psychological Association (APA) in Honolulu.

The researchers surveyed local, state and federal law enforcement investigators from 2,574 law enforcement agencies between 2001 and 2002, to identify sexual offenses against juvenile victims that originated with an online encounter and ended with the arrest of an offender.

Findings show that despite the stereotypes of Internet sex crimes against minors, offenders targeted adolescents, not younger children (99% were age 13 to 17 and none were younger than 12). Only 5% of offenders tried to deceive victims about being older adults. Only 21% lied about their sexual motives, and most of these deceptions involved insincere promises of love and romance. Few offenders used force (5%) or coercion (16%) or abduction (3%) to sexually abuse their victims. The research also suggests that it may be misleading to categorize offenders in such cases as strangers, because victims and offenders had typically communicated, both online and by telephone, for more than one month prior to meeting in person.

According to the authors, the study has several implications for prevention. Rather than

emphasize the dangers of deception, “the data suggests that a major challenge for prevention is the population of young teens who are willing to enter into voluntary sexual relationships with adults whom they meet online. This is a reality that people may be reluctant to confront, but effective prevention requires public and private acknowledgment of what actually happens in these cases,” according to the researchers. They add that teenagers may benefit from being told directly about why such relationships are a bad idea and made to understand that adults who care about their well-being would not propose sexual relationships or involve them in risky encounters.

The authors also urge prevention efforts to focus special attention on the most vulnerable populations for Internet-initiated sex crimes against minors. These include adolescents who have poor relationships with their parents, those who are lonely or depressed, or gay teenagers or those questioning their sexual orientation who turn to others on the Internet for support or information.

The authors also recommend training for law enforcement since some of the targeted youth may not initially see themselves as victims and may require sensitive interviewing in order to cooperate with investigators. The research was funded jointly by the National Center on Missing and Exploited Children and the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, and will be published online in the November issue of the *Journal of Adolescent Health.*

Presentation: “Online Victimization: Investigators’ Experiences With Internet Sex Crimes Against Minors," Kimberly J. Mitchell, Ph.D., Janis Wolak, M.A., J.D., and David Finkelhor, Ph.D., Crimes Against Children Research Center, Durham, NH; **Session 5120,** 11:00 - 11:50 AM, Sunday, August 1, Hawaii Convention Center, Level 3 – Meeting Rooms, Meeting Room 302B.

Full text of this article is available from the APA Public Affairs Office.

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The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world’s largest association of psychologists. APA’s membership includes more than 150,000 researchers, educators, clinicians, consultants and students. Through its divisions in 53 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare.

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Catherine the Holokitty's Page

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Hi! I'm Holokitty Catherine N.X. I'm a 20-year-old computer animation student in southern California. Also known to my online friends as HolokittyNX, the Feline Tactical Hologram-O-Doom (1337! ph34r!). I'm originally from Chicago, and miss the snow every day. My interests...well, they're pretty varied. I like my electronics (PDAs, cell phones, Macs, etc.), I listen to virtually every form of music from hip-hop to alternative to country, and I can't lay off the junk food. I'm 5'6, 125 lbs, have dark brown hair and eyes, and think of myself as reasonably cute. I believe that love and sex are sacred, and I consider it cruel to treat any person's sexual needs as dirty or deviant. The only wrong is in harming another person or violating their trust.

When I was younger, I was never under the impression that sex was bad or dirty. My mother's involvement in LGBT culture probably being a big contributing factor. I never thought twice about touching myself when my private parts felt good. I never thought twice about liking girls. And I didn't feel bad that one night when I was curled up with my mother and responded to an ordinary kiss on the forehead by kissing her back on the lips. I'd wanted to for as long as I could remember. And unfettered by society's presuppositions, I had no more trepidation than anyone going for their first kiss.

Realizing my attraction to her wasn't a phase she could sidestep, my mother became more open to the idea of giving me what I wanted. Kissing, then more intimate affection as I became interested in it. I was not abused, molested, or treated in any way I did not ask to be treated. I am a sexual being. I always have been a sexual being. My mother loves me as I love and trust her, and has never taken advantage of me. As far as I am concerned, our relationship is nurturing, supportive, and completely natural. Far from being sorry or ashamed of my relationship with my mother, I am grateful to her for her companionship on my path to becoming a complete and sensual woman instead of a castrated kewpie doll ideal. My experiences with my mother influence my story writing and my ethics, and I think this is for the best, as I trust no one more than I trust her. If you are curious about my experiences with my mother, feel free to POLITELY ask me in an email. Any emails sent to me may be used for my column at the Human Face of Pedophilia. I will not include your email address at the end of the letter unless you ask me to.

I realize that most adult-child sexual contact is coerced, and I have the same hatred in my heart for those who force themselves on a child as I do for any rapist. But I personally was never pushed into anything I did not want. I'm not dumb enough to think adults and parents are all saints who wouldn't push a kid into sex given the chance. And while I know for a fact that children are sexual beings (you fooled around when you were younger and you know it), it's not that simple. Even among adults, we have trouble demonstrating that a person did or didn't coerce another into sex. Kids have less control over their activities and are fed loads of BS about adults being infallible, so they're usually more subject to coercion and less likely to complain about it. Legalizing sex for children requires a more solid legal means for distinguishing between consensual sex and coerced sex. I'm pretty damned smart and I can't come up with anything like that. Until I do come up with a way to prevent coercion (or hear of one), I can't support abolishing all age of consent laws. I do believe that consent should work differently.

It's pretty obvious that more and better sex education is needed in America regardless of when

we think people can consent. Current age of consent laws are not preventing teen sex, and there is no way to do that without returning to Victorian attitudes about sex all around. The positive effects of more comprehensive sex ed are twofold. Obviously you get reduced STD transmission and teen pregnancy rates (teen pregnancy being lower today than in the 1950s). But you get another more indirect benefit. People who know more about their bodies and are taught to be okay with their sexuality are more confident and have better self-esteem. Even if we can't pin down cases of coercion, surely that confidence and the sense of owning their bodies helps protect teens against coercion by anyone. Once more comprehensive sex ed takes root, I'd try working on a standard of consent that requires passing a sex ed course. People do need to know what they're doing physically when they have this type of sex or that. They need to know the risks. Pregnancy, STDS, etc. As for knowing whether they're ready, that can't be taught. And a person's emotional readiness for sex can't be gauged any better than they gauge it themselves.

What I Write About

Most of my stories outside the Suran Continuity are classic lesbian or bisexual erotica. This as opposed to plain ol' smut. Smut doesn't turn me on. Love does. All of the links to my stories have story codes beneath them, and these codes are explained at the Alt.Sex.Stories Text Repository, which hosts this site.

I write from the heart. My stories reflect my own interests, needs, and psychology. As such, nothing I write contains coercion, force, emotional abuse, or any treatment I do not want for myself. I can't write a story about something that doesn't arouse me either sexually or intellectually, and cruelty does neither. My stories are romantic, loving, emotionally validating, and as believable as I can make them. When you read my work, I don't want the banality of the characters' everyday lives to be boring, but rather a connection between them and you. Even within the Suran Continuity, my characters have jobs, and live real lives, just like you and me. They don't have fifty gushing orgasms a day, or three breasts, or the ability to magically turn passing pedestrians into crazed sluts, because that's not accessible to a reader who has to live a real life. Their lives are meant to show you that a happy sex life can be part of your life too, not just a wishful fantasy that's beyond your reach.

Navigating the Site

I'm assuming by now you've noticed the frame to the left. These are links leading to the various sections of the site. "Home" brings you back to this page. "faq/fmc" will take to the site's Frequently Asked Questions and Frequently Made Comments area. "Journal" leads to my LiveJournal musings on things I run into from day to day. "Ethics" will take you to a page explaining my stances on various issues. "Suran" is a reference section explaining my serial, the Chronicles of Suran. "News" will take you to a list of site updates by month and day. "Stories" will take you to my erotic stories, including the Chronicles themselves. You can read the stories here, or download them to your hard drive. "Links" will take you to sites I find to be of interest, most of them about childlove. "Ask Cat" will take you to my column at the Human Face of Pedophilia. And I think "Email Me" is pretty self-explanatory.

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False Allegations of Child Abuse

When I was an associate medical examiner for Jackson County, I got a lot of enjoyment from assisting with the prosecution of real criminals, and putting bad people where they belong.

When child abuse has really occurred, it is a dreadful thing, and the perpetrators deserve to be punished as examples to others.

The system is imperfect, and occasionally an innocent person is accused on bad medical evidence. Once the initial error is made, it is very hard to stop the process.

In late March, 1996, I went to court in another state to help a working-class family which had contacted me through this home page. A 2 1/2 year old girl had obvious nonspecific vulvovaginitis, with a mix of flora on gram stain which included some gram-negative diplococci, mostly extracellular. The child was just getting over chickenpox, which might have triggered the vulvovaginitis. The pediatrician, a self-styled expert on child sexual abuse, found an "apparent healed laceration" at the 2-3 o'clock position in the hymen, no further description. Cultures and DNA probes were negative for gonorrhea. Cultures of all family members, including the grandfather, a former chief flight mechanic on a Navy ship, were negative for gonorrhea. The child denied any sexual stuff during the medical exams. The child struggled and cried a lot during the child abuse exams and cultures. A smear of the "purulent" exudate showed no white cells, only a lot of epithelial cells. Afterwards, she talked about "monster(s)" and "doctor monsters", and said, "The monster(s) put a bone in my mouth and the hair choked me" (the cotton-tipped swabs, dummies) and said "the monster had a mask" (duh).

On the strength of this evidence, the Department of Human Services told the court, "The perpetrator has been identified" as the grandfather, the evidence being that he owned a Hallowe'en mask. They told him that if he admitted his crime and got counselling, the child would be restored to the mother. The entire family refused. I was the sole medical witness for the defense, which I took for free.

I poked around the medical library, confirmed and improved on what I already knew, and was able to testify that (1) 3% of girls had a little nick in the hymen at the 2-3 o'clock position, just naturally, and around 20-30% of three-year-old girls have such innocent nicks ("apparent healed lacerations", I thought), which are no more indicative of trauma than is a double-chin; (2) relying on a gram stain in this situation was totally unacceptable as a means of diagnosing gonorrhea, and the bugs were probably Neisseria sicca or one of it kin, common commensals, which tend to be extracellular while gonorrhea bacteria are usually mostly intracellular; (3) the CDC guidelines specifically direct physicians NOT to rely on a gram stain in this situation; (4) if this were gonorrhea, there would have been white cells in the exudate, and the abundance of epithelial cells suggested "resolving chickenpox" to me; (5) the negative culture and DNA

probes satisfied me that this was almost certainly not gonorrhea; (6) there are published, empirical criteria for the physical examination of a girl suspected of having been sexually abused, and the "expert" had utterly failed to address or meet these; (7) often you never find the cause of vulvovaginitis in a child. (I should have had the statistic, which is 70%; I'm sorry I didn't.)

We won.

From now on, I am available as a medical expert in other cases in which I'm convinced that an allegation of child abuse is false. **I do not charge for an initial chat, and I do the cases where the person is clearly innocent pro bono.** Please place links to my page as you think would be useful. Dean Tong

False Allegations

Family Rights Organization National Taskforce

Gary Preble is an attorney at 2120 State Avenue NE, Olympia, WA 98506, 360-943-6960, **preble@olywa.net**.

Yet another resources is Tony Barreira, **barr@mail.autobahn.mb.ca** and Parents Helping Parents, 35 Tallmara Street, Winnipeg MB R2R 2G1 CANADA 204-256-8912.

Men's HOTLINE : 512-472-3237 : men@menhotline.org
807 Brazos, Suite 315 : Austin, Texas 78701
A service of the Men's Health Network : Washington, D.C.

Men's Health Network: mensnet@CapAccess.org
Edward Nichols MSW: a social worker with an interest in false allegations of sexual abuse **EZTherapy@aol.com>**. To Receive Free Report: Email: eztherapy@aol.com and request "Free Report" Report will be sent by return email as an attached file.

Addendum: I receive many inquiries as a result of this page. Regrettably, many of the charges turn out (in my opinion, after considering the evidence) to be true. (If you're a "child protection activist" planning to send me one of those anonymous E-mails, please be reassured that I'm really not a "butcher", "murderer", "idiot" or whatever.)

I cannot help you unless the case against you is based on bad medical testimony.

From working in this area, I've reached the conclusion that most doctors don't want to go against the local prosecutors, or defend somebody accused of a vile crime, no matter how silly the charges. Since I'm not a family or political man, I can do this more freely than others, and enjoy the challenge.

Since I posted this, I've had additional cases of false accusations, including:

- A case of a baby who was killed when another child jumped off a bed and by a freaky but plausable mechanism, already known from other cases, ruptured the baby's heart. The autopsy matched the family's story perfectly (even elegantly), but the case was unusual and there was dissension in the scientific literature about this kind of injury. I submitted a written report, and following the local medical examiner's testimony and cross-examination, and prior to the defense's time, the judge dismissed the case.

- A teenaged boy who apparently had common jock itch, which was mistaken by a paraprofessional for herpes, and an adult was charged with causing this by sodomizing the boy; I wrote a letter and have heard no more since.

- A young teenaged girl made assorted accusations, some clearly untrue, against her natural father, who was in a custody battle with the mother. The local child-protection doctor evidently mistook the white line that sometimes runs from from the posterior aspect of the vulva to the anus as a healed laceration. The case is pending.

- Not child abuse, but similar... A man died of a heart attack while smoking in his chair, and burned after he died. Sonja Casey, was wrongfully (and ridiculously) convicted of a torch murder. My letter written in an attempt to obtain her release got me a paragraph in the Wall Street Journal. She was released.

- Not child abuse, but similar... A woman died with extremely advanced Alzheimer's, who had been fed by gastrostomy for 7 years (she hadn't known to eat for all this time), Finally she developed the cachexia that happens to these people at the very end. Death was actually due to heart failure, and it was inevitable considering the extremely advanced Alzheimer's. Although there was food in the gut, plenty of feces in the colon, and plenty of inner bodyfat, an activist pushed and the pathologist was willing to call it death by intentional starvation. Incredibly, the state prosecuted the caretaker for murder. The trial was highly political, with a guy from the state capitol at the prosecutor's table. I got to tell the court that the medical examiner had also overlooked two obvious brain infarcts that most second-year medical students would spot easily. The defendant was acquitted of the murder charge.

- Not child abuse, but similar... A teenaged boy argued with his girlfriend's father in a weightroom. Later that day, the father complained of chest pain and died. A huge blood clot was found in a major coronary artery. The local medical examiner took a photograph of what appeared to be a normal skull marking which happened to be a bit prominent in the dead man, and a bit of blood from the extraction of the brain. He called the marking a fracture, though he did not give evidence that the bone fragments were separable, and called the death a murder from being struck on the head. As a result of this travesty, the teen did two years in jail. My consultation on the case helped with his ultimate acquittal.

- A baby who died of SIDS also had a full diaper and was not found for 8 hours. Some red apparent abrasions were identified by the nurses when the body was undressed and washed. These were not in an assaultive pattern. Microscopy showed these to be the work of fecal clostridia, which were obvious on the slide, where they formed a bacterial lawn over the lesion. I was shocked and dismayed that the local pathologist wouldn't recognize this. I decided that he was either incompetent or just crooked. The prosecutor had nothing to say about the scientific stuff, but actually screamed at me because I read "Playboy" and complained about my link to VOCAL. This is how low some prosecutors can sink in a politicized case. Outcome unknown.

- I have reviewed two cases from Rhode Island in which a nurse-activist has testified, falsely, that her review of the literature indicates (in one case) mere failure of the anus to wink when the buttocks are spread (curiously she calls this the "relaxation response") is a good indicator for buggery, and (in the other case) labial adhesions are a strong sign of abuse. At the time she gave testimony in each case, the actual refereed medical literature indicated both claims were NOT true. This is at best a surprising display of ignorance from somebody who should know better, and at worst criminal perjury. On the evidence I have seen so far, this has resulted in one wrongful, and one dubious, conviction. Both men are in prison.

A man, also in Rhode Island, has served 11 years in prison because of testimony by a pediatric resident. Errors included saying that an opening in the hymen of 1 cm was excessively large for a six year old girl (it's just within the 2 SD), that scarring could be produced by rubbing, that a child who easily accepted an examiner's digital anal penetration had probably been abused, and that skin tags on the anus suggested sexual abuse. The child had a groin rash, which I thought was a better explanation for the "scarring" (sounded like dermatitis) on the perineum. And she had been receiving suppositories, which explained why she permitted anal digital penetration more easily than did other children. He tells me the accusation followed his finding his wife in bed with another man. I wrote him explaining the mistakes, and I have asked him to have the physician who testified against him review her testimony and reconsider in light of today's improved knowledge.

A man in the southern US was accused by his sixteen-year-old daughter of many episodes of penetration. The examiner testified that a pattern of scarring was seen at the edges of the ruptured hymen which indicated that intercourse was not consensual. She could not describe the identifying features of this pattern. During cross-examination, she admitted this was not something she could find in a textbook, but became very indignant, saying her education was not on trial here, that she doesn't memorize textbooks, and so forth. Of course, her claim is total bunk and I told this to the interested parties. Outcome unknown.

Except for two cases which went through a referral agency, I've handled these pro bono.

Addendum: July 2003.

Understanding the Sex Abuse Exam

This is offered with the hope of helping both prosecutors and defense attorneys recognize errors by physicians that might cause a miscarriage of justice either way.

My focus is on tissue reactions. I have performed eight clinical rape exams as a team member, including two on children, while a resident. I think I am current in my reading on how to interpret physical findings in suspected abuse. Unlike two decades ago, there are clear standards, and they match what I know about disease and injury. And I probably have a better grasp of how tissue responds to injury than do the clinicians who have made the clinical guides.

Here is a list of Adams proposed classification of anogenital fidnings in children, from Pediatrics 94: 310, 1994. I chose this because it's been available for almost a decade and ought to be familiar to anybody claiming to be an expert. I have added my notes on WHY these make sense.

Life has taught me to trust physical evidence above what anybody tells me, no matter how seemingly "sincere". You'll have to ask somebody else how often a child is coached to tell a fabricated story during a divorce or custody battle.

Although this is mainstream... as of this writing (July 2003), the criteria for the physical exam in suspected child abuse have been almost impossible to find online. (It's no surprise that most people who post on the internet are concerned with politics instead of with truth.) For example, the 2001 proposed classification was only located at a relatively obscure Filipino site here. The Filipinos included a much-deserved thank-you to Dr. Joyce Adams.

Proposed Classification of Anogenital Findings in Children (1994)

Normal: Class I

- Periurethral bands
- Intravaginal ridges or columns
- Increased erythema in the sulcus [Note 1]
- Hymeneal tags, mounds, or bumps [Note 2]
- Elongated hymeneal orifice in an obese child
- Ample posterior hymenal rim (1-2 mm wide) [Note 3]

- Estrogen changes (thickened, redundant hymen) [Note 4]
- Diastasis ani / smooth area at 6 or 12 o'clock in perianal area [Note 5]
- Anal tag / thickened fold at midline [Note 6]

[Note 7]

Nonspecific findings (Class II).

"Findings that may be caused by sexual abuse, but may also be caused by other medical conditions. History is vital in determining significance.

- Erythema of vestibule or perianal tissues [Note 8]
- Increased vascularity of vestibule or hymen [Note 9]
- Labial adhesions [Note 10]
- Rolled hymenal edges in the knee-chest position [Note 11]
- Narrow hymenal rim, but at least 1 mm wide [Note 12]
- Vaginal discharge [Note 13]
- Anal fissures
[Note 14]
- Flattened anal folds [Note 15]
- Thickened anal folds [Note 16]
- Anal gaping with stool present [Note 17]
- Venous congestion of perianal tissues, delayed in exam [Note 18]

Suspicious for abuse (Class 3)

"Findings should prompt the examiner to question the child carefully about possible abuse. May or may not require a report to Protective Services in the absence of a history."

- Enlarged hymenal opening -- greater than two SD's [standard deviations] from nonabused study (McCann et al.)[Note 19]

- Immediate anal dilitation of at least 15 mm with stool not visible or palpable in rectal vault [Note 20]
- Immediate, extensive venous congestion of perianal tissues [Note 21]
- Distorted, irregular anal folds [Note 22]
- Posterior hymenal rim less than 1 mm in all views [Note 23]
- Condyloma acuminata in a child [Note 24]
- Acute abrasions or lacerations in the vestibule or on the labia (not involving the hymen), or perianal lacerations [Note 25]

Suggestive of Abuse / Penetration (Class 4)

- Combination of two or more suspicious anal findings or two or more suspicious genital findings
- Scar or fresh laceration of the posterior fourchette with sparing of the hymen [Note 26]
- Scar in perianal area (must take history into consideration) [Note 27]

Clear Evidence of Penetrating Injury (Class 5)

- Areas with an absence of humenal tissue, (below the 3 o'clock to 9 o'clock line with patient supine) which is confirmed in the knee-chest position
- Hymenal transections or lacerations
- Perianal laceration extending beyond (deep to) the external anal sphincter
- Laceration of posterior fourchette, extending to involve hymen
- Scar of posterior fourchette associated with a loss of hymenal tissue between 5 and 7 o'clock

Note 1: The sulcus is the area around the glans of the clitoris. Redness here means nothing.

Note 2: These are common normal variants, like having a split in your chin. If the bump is about

the same color as the nearby tissue, it can't be a scar. I would have added that notches in the anterior half of the hymen (i.e., 9 o'clock to 3 o'clock with the patient supine) mean nothing.

Note 3: The anterior hymenal rim may be very slim or absent as a normal variant; this was the case with JonBenet Ramsey and the pathologist recognized it as normal.

Note 4: I read testimony of one examiner who said that thickening implied scarring and thus prior abuse. This flunks introductory "Pathology" in medical school. Scar usually contracts. Estrogen renders the hymen thicker and more redundant / wrinkly so it stretches easier.

Note 5: Diastasis ani means the visible portion of the anal opening appears slightly open when the buttocks are spread. This means nothing. The mucosal folds (i.e., the little stretchable wrinkles that are present when the anus is not distended by stool) in front and back are often much more shallow than elsewhere, and this is a normal variation. I have seen both of these called evidence of sexual abuse.

Note 6: A tag is a bit of redundant skin. You can see skin tags around the anus on anybody, or on the necks or elsewhere on the skin especially of older folks. I have had two cases of physicians calling anal skin tags evidence of anal penetration. You have to wonder whether they've done many rectal exams on normal people. A "sentinal pile" is edema or venous dilation just below a fissure. If somebody has a fissue, it'll be obvious already.

Note 7: I would have added a few others. These should be known to every physician, but evidently aren't.

> A white line running posteriorly from the posterior forchette, over the skin in the midline, is a normal variant. As I noted above, I've seen this called a "scar" and thus proof of severe abuse. It is a normal anatomic variant.
>
> A crescentic hymen, i.e., with no tissue at all between 11 o'clock and 1 o'clock or thereabouts in the supine position, is a perfectly normal variant. So is a cribriform ("sieve-like") with several openings.
>
> I am not aware of any reason to believe that if the anal sphincter relaxes but only after one second following spreading of the buttocks, this indicates anal intercourse. However, as I've noted, this was stated as fact in court, leading to what seems to me to be a faulty conviction.
>
> In one case, Division of Family Services people stated that since the suspect had been given a routine urinalysis during a doctor's office visit, it was proof that the doctor suspected venereal disease. I hope nobody who lives in your community is this ignorant.

One of the toughest calls is the "normal" exam when the child claims abuse. In evaluating these claims, there are a couple of things to consider.

First, the tissues of the vulva, including the hymen, can heal minor trauma after a few weeks with no scar.

Second, the ring around the hymen is quite sensitive in a pre-pubertal girl, and touching it will hurt considerably.

Third, fondling and digital penetration of just the vestibule (a girl will probably still call this the vagina) and/or anus isn't going to leave any physical changes except perhaps transient redness.

Fourth, despite "it's normal to be normal", I cannot believe, and am not aware of any evidence, that penetrating a girl of any age with an erect normal-sized penis is likely to leave the hymen intact.

I've seen a few cases in which an examiner finds no abnormality whatsoever, and signs the case out, "Normal examination, consistent with sexual abuse." In pathology (and so far as I know, in every other branch of real medicine), when I say "consistent with", I mean there is some solid physical evidence that this is the case. I was taught to sign out a negative rape / sex abuse exam, "No physical evidence of..." If these examiners were honest (and I use this word after reflection), they would say instead, "No physical evidence of abuse. NOTE: A normal exam does not rule out fondling."

Note 8. Erythema simply means increased blood flow, as when in blushing or exercise or after scratching. In 1988, a sex abuse examiner in Rhode Island noted erythema of the posterior mucosal surface of the vulva on a six year old girl. She testified that this was likely the result of digital penetration of the vulva six months previously. This is even stupider because the child had a groin rash, likely from poor hygiene.

Note 9. Increased vascularity means that the blood vessels, i.e., the surface veins, are easier to see. This usually reflects the changes of chronic inflammation, in which the epithelium may be thickened and the mucosa may be edematous and infiltrated by white cells. On the skin, we call this a chronic dermatitis. Increased vascularity is also seen in a healing true scar. The two are easy to confuse, especially if the examiner doesn't reflect that a scar must be localized and must have been preceeded by abundant hemorrhage. Rubbing could produce a dermatitis / mucositis, as could any other kind of irritation, inflammation, or infection. However, this won't last more than a few days.

Note 10. Labial adhesions are fibrin or other condensed protein connecting the labia. It's fairly common in young girls and evidently "just happens". Of course, scabbing following severe

abuse could do the same thing. One of our medical students has a daughter who was diagnosed as an intersex by the family doctor and the family was on its way to genetic counselling. Asked for my opinion first, I demonstrated the ease with which labial adhesions could be separated with a wet Q-tip. The term "friability" has different meanings in clinical medicine ("bleeds easily when manipulated") and pathology ("crumbly").

Note 11: There's more tissue here than usual. This can be normal, or the result of inflammation from another cause, or the result of deformation of the hymen from trauma.

Note 12: I believe the authors are referring to the posterior portion of the hymen.

Note 13: Nonspecific vulvovaginitis in children can result from systemic illness, poor hygiene, or "just happen". Finding gram-negative diplococci on gram smear is not evidence of gonorrhea in the female. A negative culture / gene probe rules out untreated gonorreha.

Note 14: A genuine anal fissure is very painful. This will not be a surprise finding on examination. Resources suggest all fissures are longitudinal, i.e., radiating out from the anal opening; however, deep ones can be transverse.

Note 15: Flattened anal folds would only result from abuse which would produce additional evidence trauma, with deformation of the underlying connective tissue (marked remodelling in a scar) or marked associated local edema (obliterating the folds by stretching). The idea that fondling will flatten mucosal folds is as ridiculous as claiming that rubbing your lips will lead to an area that doesn't wrinkle when you pucker your mouth.

Note 16: Thickening (i.e., increased prominence) of the anal folds would be typical of a chronic dermatitis / mucositis. The trauma would have to be equivalent to what would produce a rash or signs of injury on the lips.

Under development

Overall Assessment of the Likelihood of Sexual Abuse (1994)

Class 1: No evidence of abuse

- Normal exam, no history, no behavioral changes, no witnessed abuse
- Nonspecific findings with another known etiology, and no history or behavioral changes
- Child considered at risk for sexual abuse, but gives no history and has nonspecific behavior changes

Class 2: Possible abuse

- Class 1, 2, or 3 findings in combination with significant behavioral changes, especially sexualized behaviors, but child unable to give history of abuse
- Presence of condyloma or herpes 1 (genital) in the absence of a history of abuse, and with otherwise normal exam
- Class 3 findings with no disclosure of abuse

Class 3: Probable abuse

- Child gives a clear, consistent, detailed description of molestation, with or without other findings present
- Chass 4 or 5 findings in a child, with or without a history of abuse, in the absence of any convincing history of accidental penetrating injury
- Culture-proven infection with Chlamydia trachomatis (child over 2 years of age) in a prepubertal child. Also culture proven herpes type 2 infection in a child, or documented Trichomonas infection

Class 4. Definite evidence of abuse or sexual contact

- Finding of sperm or seminal fluid in or on a child's body
- Witnesed episdoe of sexual molestation. This also appplies to cases where pronographic photographs or videotapes are acquired as evidence
- Nonaccidental, blunt penetrating injury to the vaginal or anal orifice
- Positive, confirmed cultures for Neisseria gonorrhoeae in a prepubertal child, or serologic confirmation of acquired syphilis

By the time these were written, the literature shows they were common knowledge. **In my opinion, any physician or other examiner offering medical testimony substantially at variance from these proposed standards after the year 1994 was doing sub-standard work.**

Development of the scheme continued. Here is the 2001 version, from Child Maltreatment 6(1):

31. 2001.

Anogenital Findings on Examination (2001)

Normal

- Peri-urethral or vestibular bands
- Longitudinal intravaginal ridges or columns
- Hymenal tags
- Hymenal bump or mound
- Linea vestibularis
- Hymenal cleft/notch in the anterior (superior) half of the hymenal rim, on or above the 3 o'clock-9 o'clock line, patient supine
- External hymenal ridge

Normal Variants

- Septate hymen
- Failure in midline fusion
- Groove in the fossa in a pubertal female
- Diastasis ani
- Perianal skin tag
- Increased peri-anal skin pigmentation

Other Conditions

- Hemantiomas of the labia, hymen, or perihymenal area (may give the appearance of bruising or submucosal hemorrhage)
- Lichen sclerosus et atrophicus (may result in friability and bleeding)
- Behcet's disease (causes genital and oral ulcers, may be mistaken for herpes simplex

lesions)

- Streptococcal cellulitis of perianal tissues (causes red, inflamed tissues)
- Molluscum contagiosum (warty lesions)
- Verruca vulgaris (common warts)
- Vaginitis caused by streptococcus or enteric organisms
- Urethral prolapse (causes bleeding, appearance of trauma)
- Vaginal foreign bodies (may cause bleeding, discharge)

Non-Specific Findings

- Erythema (redness) of the vestibule or perianal tissues (may be due to irritants, infection or trauma)
- Increased vascularity (dilation of existing blood vessels) of vestibule (may be due to local irritants)
- Labial adhesions (may be due to irritation or rubbing)
- Vaginal discharge (many causes)
- Friability of the posterior fourchette or commissure (may be due to irritation, infection, or may be caused by examiner's traction on the labia majora)
- "Thickened hymen" (may be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma)
- Apparent genital warts (may be skin tags or warts not of the genital type, may be condyloma accuminata which was acquired from perinatal transmission or other non-sexual transmission)
- Anal fissures (usually due to constipation or peri-anal irritation)
- Flattened anal folds (may be due to relaxation of the external sphincter)
- Anal dilation with stool present (a normal reflex)
- Venous congestion, or venous pooling (usually due to positioning of child, also seen in constipation)

- Vaginal bleeding (may be from other sources, such as urethra, or may be due to vaginal infections, vaginal foreign body, or accidental trauma)

Suggestive of Abuse

- Marked, immediate dilation of the anus, with no stool visible or palpable in the rectal vault, when the child is examined in the knee-chest position, provided there is no history of encopresis, chronic constipation, neurological deficits, or sedation
- Hymenal notch/cleft in the posterior (inferior) portion of the hymenal rim, extending nearly to the faginal floor. (often an artifact of examination technique, but if persisting in all examination positions, may be due to previous blunt force or penetrating trauma)
- Acute abrasions, lacerations or bruising of labia, peri-hymenal tissues, or perineum (may be from accidental trauma, or may be due to dermatological conditions such as lichen sclerosus or hemangiomas)
- Bite marks or suction marks on the genitalia or inner thighs
- Scar or fresh laceration of the posterior fourchette, not involving the hymen (may be caused by accidental injury)
- Perianal scar (rare, may be due to other medical conditions such as Crohn's disease, or from pervious medical procedures)

Clar Evidence of Blunt Force or Penetrating Trauma

- Laceration of the hymen, acute
- Ecchymosis (bruising) on the hymen
- Perianal lacerations extending deep to the external anal sphincter
- Hymenal transection (healed). An area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall.
- Absence of hymenal tissue. Wide aeras in the posterior (inferior) half of teh hymenal rim with an absence of hymenal tissues, extending to the base of the hymen, which is confirmed in the knee-chest position.

Overall Assessment of Likelihood of Abuse (2001)

NOTE by me: This seems much more helpful to me than simply writing, "Normal exam consistent with sexual abuse." I think that these criteria should now be considered standard, and I would question the integrity of an examiner who deviates substantially from this outline.

No indication of abuse

- Normal exam, no history, no behavioral changes, no witnessed abuse
- Nonspecific findings with another known or likely explanation and no history of abuse or behavioral changes
- Child considered at risk for sexual abuse but gives no history and has only nonspecific behavior changes
- Physical findings of injury consistent with history of accidental injury that is clear and believable

Possible abuse

- Normal, normal variant or nonspecific findings in combination with significant behavior changes, especially sexualized behaviors, but child unable to give a history of abuse
- Herpes type I anogenital lesions, in the absence of a history of abuse and with an otherwise normal examination
- Condyloma accuminata, with otherwise normal examination; no other STDs present, and child gives no history of abuse. Condyloma in a child older than 3-5 years is more likely to be from sexual transmission, and a thorough investigation must be done.
- Child has made a statement but statement is not sufficiently detailed, given the child's developmental level; is not consistent; or was obtained by the use of leading questions concerning physical findings with no disclosure of abuse

Probable abuse

- Child has given a spontaneous, clear, consistent, and detailed description of being molested, with or without abnormal or positive physical findings on examination
- Positive culture (not rapid antigen test) for Chlamydia trachomatis from genital area in

prepubertal child, or cervix in an adolescent female assuming that perinatal tarnsmission has been ruled out

- Positive culture for herpes simplex type 2, from genital or anal lesions
- Trichomonas infection, diagnosed by wet mount or culture from vaginal swab, if perinatal transmission has been ruled out

Definite evidence of abuse or sexual contact

- Clear physical evidence fo blunt force or penetrating trauma with no history of accident
- Finding sperm or seminal fluid in or on a child's body
- Pregnancy
- Positive, confirmed cultures for N. gonorrhea from vaginal, urethral, anal, or pharyngeal source
- Evidence of syphilis acquired after delivery (i.e., not perinatally acquired)
- Cases where photographs or videotape show a child being abused
- HIV infection, with no possibility of perinatal transmission or transmission via blood produts or contaminated needles

Please click here to see the Adams 2003 classification, as it was originally placed online by the medical students at Harvard.

Normal hymen anatomy: Pediatrics 89: 387, 1992.

Google on false allegations
"Have we been misled?"
falseallegations.com
falseabuse.com
American Family Physician
J.J.Johnston, Esq. handles sex crimes in Southern California

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Is pedophilia a mental disorder?

Discussion in Archives of Sexual Behavior

Report by Frans Gieles

The December 2002 issue is a *special* about pedophilia.
Richard Green argues for the removal of pedophilia from the DSM, the famous handbook that defines psychiatric illnesses, among which is pedophilia, albeit under certain conditions.
Gunter Schmidt says that not all pedophiles are per se unscrupulous molesters; instead pedophiles have a problem of conscience, a moral dilemma, and they deserve respect rather than condemnation.
There follow *peer comments* from 21 authors give peer comments, after which Green and Schmidt reply.
Ipce members should buy and read this special issue.
In this Newsletter, I give the following report.

Green's article

Richard Green was very actively involved thirty years ago in the removal of homosexuality from the DSM list of mental disorders. As is known, homosexuality was successfully removed in the early seventies. Now he argues for the removal of pedophilia from the same list.

Green makes a distinction (also made by the Rind team - and by me) between three kinds of discussions or discourses: the legal one, the moral one, and the medical one. To give my own examples: starting a war may be legally correct, - IMHO it is morally incorrect - but it is not a medical illness. Smoking hash or drinking alcohol before a certain age may be legally wrong, but one might see no moral objections; a doctor might counter-advise it, but it is no illness per se.
A pedophile who activates his or her desires into action may infringe the law; one may discuss if it is morally right or wrong, but another kind of question is if her or his is actions are the outcome of a mental disorder. Moreover: does a pedophile who inhibits her or his behavior within any legal or moral limits, still have a mental disorder through his feelings *per se*? No, says Green.

Green starts by presenting cross-cultural arguments. Intimacy between generations is spread worldwide among so many cultures and in so many eras, that one cannot reasonably argue that all those people have a mental disorder. They may have different cultural customs and opinions. Additionally many primates have these kinds of costoms.

The next group of arguments refers to personality characteristics of people with pedophilic feelings. Here we have a sampling problem, because most research has been performed on clinical and legal samples. If problematic characteristics are found, the choice of the sample, as well as the clinical or legal situation might cause these problems.

> "Cause and effect here is arguable between social consequences of pedophilia and psychiatric problems promoting pedophilia".

Green refers to a study of a non-legal and non-clinical sample:

> A unique study at the Institute of Psychiatry of the Maudsley Hospital in London evaluated non-prisoner, non-patient pedophiles (Wilson & Cox, 1983). The men were obtained through the *Paedophile Information Exchange*. The psychometric instrument utilized, it being a Maudsley study, was the Eysenck Personality Questionnaire (EPQ). The EPQ is scored on three main axes of personality: extraversion, neuroticism, and psychoticism. There is also a "Lie Scale" to assess "faking good." A total of 77 pedophiles were studied, with an age range of 20 - 60. They were compared with 400 controls.
>
> Pedophiles were significantly more introverted. Psychoticism, or thought disorder, was slightly elevated but not to a pathological level. Occupational groups with similar scores to the pedophiles are doctors and architects. Neuroticism scores were slightly higher than controls, but not clinically abnormal. Pedophile scores were similar to actors and students. The lie scales did not differ. Wilson and Cox (1983) concluded that
>
> "... the most striking thing about these results is how normal the paedophiles appear to be according to their scores on these major personality dimensions - particularly the two that are clinically relevant [neuroticism and psychoticism]. ... introversion ... in itself is not usually thought of as pathological." (p. 57)
>
> Another researcher, Howitt (1998), reached a similar conclusion:
> "The possibility of finding a simple personality profile that differentiates pedophiles from other men has appeared increasingly unrealistic as the research and clinical base has widened. Simplistic notions such as social inadequacy driving men to sex with children become unviable as highly socially skilled pedophiles are found" (p. 44).

Another argument for the normality of pedophilic feelings are the percentages of 'normal people' who are said to feel attracted to children (about 20 to 25%), and who react with penile erection to 'pedophilic' stimuli: more the 25%. One cannot reasonably argue that about one quarter of the population is mentally ill.

The last group of arguments refers to the DSM itself: its inconsistencies.

> So what then of the pedophile who does not act on the fantasies or urges with a child? Where does the DSM leave us? In Wonderland. If a person does not act on the fantasies or urges of pedophilia, he is not a pedophile. A person not distressed over the urges or fantasies and who just repeatedly masturbates to them has no disorder. But a person who is not distressed over them and has sexual contact with a child does have a mental disorder. The APA position with its DSM catalogue is logically incoherent.
>
> Confronted with the paradox that in contrast to other conditions designated a mental disorder, such as with persons who hand-wash to the point of bleeding and can't touch a door knob, or who are harassed by voices threatening their personal destruction, many pedophiles are not distressed by their erotic interest, aside from the fear of incarceration. Some celebrate their interests, organize politically, and publish magazines or books.
>
> So to deal with this paradox, DSM dug itself deep into a logical ditch. If a person's erotic fantasies are primarily of children and masturbatory imagined partners are children, that person does not have a mental illness, without more. Never mind these mental processes, those readers of DSM who are psychiatrists and treaters of the disordered mind.
>
> These people with these fantasies do not have a mental disease unless that person translates thought into action. This turns psychiatry on its head. Certainly a society can set rules on sexual conduct and proscribe child-adult sex and invoke sanctions for transgressors. But that is the province of the law and the penal system. The DSM should not provide psychiatry with jurisdiction over an act any more than it should provide the law with jurisdiction over a thought.

Green concludes:

> Sexual arousal patterns to children are subjectively reported and physiologically demonstrable in a substantial minority of "normal" people. Historically, they have been common and accepted in varying cultures at varying times.
> This does not mean that they must be accepted culturally and legally today. The question is: Do they constitute a mental illness? Not unless we declare a lot of people in many cultures and in much of the past to be mentally ill. And certainly not by the criteria of DSM.

Gunter Schmidt's article

Schmidt argues for a reasonable discussion based on facts, not on moral prejudices or emotional indignation. Also Schmidt refers to the different kinds of discussions or discourses that are involved here.

> However, the tendency to polarize and over-generalize is strong. Both, those inclined to de-emphasize the severity of the problem and those bent upon blowing it out of all proportion, distort the reality of children who are drawn into sexual contact with adults, colonizing their experience, their memories, and their own assessments.
> It seems to me that one of the prerequisites for a more reasonable discussion is to disentangle the confusion of moral and clinical discourses. This requires that we argue,

- from a moral standpoint, where morals are at issue and,
- from a clinical point of view, when it comes to traumatizing effects.

> Above all, we should not clothe moral judgments in the garb of clinical "expertocratic" language.
> I shall preface my attempt to disentangle the confusion of these two levels of discourse [...].

There are *two* discourses going on now concerning this subject:

> [...] we find ourselves in the midst of the moral discourse, or rather of the moral discourses, for there are at least two, and even they must be clearly distinguished from one another.

- **The first of these** is the traditional one, the one I refer to as the child molester discourse. It is blunt, highly emotional, over-generalized, full of prejudices -- you find it in the boulevard press but not only there. [...]
- **Today, there is a second form** of moral discourse, which presumably has a much greater impact on the current social situation of pedophiles today than the loud outcries of fundamentalists or barstool moralists. It represents a view based upon a broad social consensus. As an enlightened discourse on morality, it is particularly virulent in liberal circles, in groups which were once rather more inclined to caution and concession in their judgment of pedophiles.
  This is the discourse of sexual self-determination or equal rights, which has assumed a dominant role in the general view of sexuality today.

In the modern discourse between the free and intimate citizens, many forms of erotic and sexual behavior are freed from old conservative morals; nowadays, they are seen as free

choices of free citizens. Except pedophilia.

> Does pedophilia inexorably and categorically violate the morality of consent and intimate citizenship? Of course, there can be no question that it does so wherever violence, coercion, extortion, and emotional manipulation are employed. Thus, we must articulate the problem more specifically. Can there be sexual consensus at all between adults and children?
>
> Many pedophiles say there can be, arguing roughly along these lines: "I want nothing more than what the child wants. I can enjoy it only when the child enjoys it as well."
> This message comes across in a number of different versions. In numerous conversations with pedophiles seeking advice, I have rarely found myself compelled to doubt the subjective truth of such statements.

Schmidt then gives an example, a scenario in which a boy and a men play with an electric train. One might imagine the end of the story. Schmidt argues that the boy and the man "are on different pages" or have different scripts, different interpretations of the situation. The boy wants to play, the man desires more intimacy. There seems to be consent, but there is none.

> Thus, the problem of sexual consensus between the adult and the child lies in the disparity of scenarios. Only by ignoring the aspect of social meaning is it possible to see consensus or at least the absence of dissent in such a situation.
>
> Only the adult is aware of the disparity of scenarios and only he is in a position to overcome it, simply by saying what it is he really wants -- and in that case the boy's "no" would undoubtedly come more quickly and emphatically.
>
> [...]I find it difficult to imagine consensual sexual acts between children and adults. There are undoubtedly exceptions, which would include cases of boys just entering puberty and who have masturbated or had other sexual experiences leading to orgasm with peers, that is, of boys who can be expected to know "what the score is" and who have experienced their own sexuality without adult participation and perhaps become curious about how adults would react in contact with them and about what they might experience with an adult.

Schmidt then mentions Kinsey's research, and describes the modern discussion about 'trauma or no trauma'. This discussion is one with two opposed camps. He proposes two fundamental points to have in mind for a more rational and scientific discussion:

- (1) Sexual contacts between adults and children pose a risk of lasting trauma for the latter even when they do not involve violence or the patent use of force, the risk is presumably greater the younger the child is, and is likely to rise in proportion to a number of other factors [...]
- (2) There are many cases of nonconsensual sexual contacts between adults and children that are not traumatic for the child, although they do indeed violate his or her right of self-determination. Nonconsensual experiences are not categorically traumatic; what is morally unacceptable is not necessarily injurious. [...]

Schmidt quotes Kinsey and the Rind *et al.* research to lay the foundation for the second statement. The first statement, however, describing the risk of trauma, places the pedophile in a dilemma.

> The dilemma is tragic because the pedophile's sexual orientation is deeply rooted in the basic structure of his identity. Pedophilia is as much a part of him as is love for the same or opposite sex for the homosexual or heterosexual man or woman, the difference being that the one is accepted, while the other is categorically forbidden and virtually impossible to realize.
> In view of the pedophile's burden, the necessity of denying himself the experience of love and sexuality, he deserves respect, rather than contempt.

The peer commentaries

I shall give a short overview, summarizing the 21 authors in my own words.

Fred Berlin

agrees with both authors in as far as he says one might treat pedophiles, but one should not reject them, rather respect them. Because a child is not always traumatized, one should not routinely give treatment to any child who had any sexual experience, nor to every person with pedophilic feelings.

Wolfgang Berner

agrees with the normality of penile erections to 'pedophilic' stimuli - he quotes a 27.7% from literature - but adds that this is not necessarily a reference to a sexual orientation. An orientation is more than a single reaction of the body.

Vern Bullough

accepts the conclusions of Wilson & Cox (1983) that people with pedophilic feelings are quite normal people who not should be demonized. Some behavior might be socially incorrect, but

that is not the same as pathological. As long as these people limit themselves to have fantasies, nothing is wrong. If some people have to change their behavior, this is a case of re-educating those people, not of treatment or curing an illness.

Alan Dixson

is simple in his comment: that pedophilia is a mental distortion: "bizarre", "abnormal". End of discussion.

Julia Ericksen

gives a good summary of what both authors have said. She remarks that it may be so that intergenerational intimacy has been or still is quite normal in other eras and cultures - we still live in our time and culture. It is the culture that determinates one's sexual orientation. So, a 'deviant' orientation is not *per se* a pathological deviance, but a cultural one. Thus, for insight of the phenomenon, have a look at the culture one lives in, not at the person. Ericksen does not believe in a genetically fixed sexual orientation.

Dean Fazekas

agrees in so far as he says that pedophilia, child molester, or incest offender, cannot be a diagnosis. However, he does not believe in the possibility of consent. He acknowledges that not all pedophiles behave wrongly. He provides a remarkable argument that there is always harm to the child: we spend so much resources and time to treat children as well as the offenders, that there must be harm.

Richard Friedman

agrees only on the point that one should not demonize pedophiles. One should keep giving them treatment, including changing their too romantic, thus distorted, ways of thinking.

George Gaither

disagrees with both authors. We need the DSM, he remarkably argues, so that we have the resources to continue our treatment and research. He keeps viewing a pedophilic orientation as a mental disorder to be treated and changed. He disagrees with the APA view that this is not possible.

Richard Krueger & Meg Kaplan

also disagree with both authors. In other times and cultures pedophilia surely has been viewed

as a disorder. They make comparisons with drug dependency and suggest that pedophilia can better be viewed as a disease than as an immoral act; for immoral acts, there is only a prison, but for diseases, treatment is possible. Thus, let's keep the DSM, and the possibilities of treatment, as they are. Only then understanding is possible.

Ron Langevin

pleads for revision of the DSM paragraph about pedophilia, but not for removing it. OK, let other cultures have their view, that is no argument: we have our own view. He sees biases in the research quoted by Green, and refuses to see a penile erection as a sign of a sexual orientation.

Michael Miner

also says that we do not live in Polynesia in far-off times, but in our own time and culture and its views. As with our culture, Miner sees pedophilia as a disorder, just because the effects of pedophilic behavior: bring harm to the child, and shame, social isolation and prison to the adult. The disorder is not one of sexual orientation as such, but lack of impulse control - just as it is in cases of pathological gambling, drugs or alcohol use.

Charles Moser

strongly agrees with Green. None of the paraphilias should have a place in the DSM list of disorders. A sexual desire can never be a disorder. Sexuality is lead by culture, not by illnesses.

Emil Ng,

from China, shows the politeness and the preference for nuances of his country's culture. Doing so, he gives a cross-cultural view on the phenomena, putting narrow Western views into a broader perspective. Chinese literature does not ascribe any mental or medical diagnosis of pedophilia or homosexuality to "romantic affairs" between children or between adults and children, although they are not difficult to find in that tradition. Since ages, people marry quite young in China.

His comments on the Western ways of thinking and acting are quite incisive. The Western discussion about consent and traumas is "hypocritical", he says. Only in sexual matters western adults worry about consent and traumas, not in all other matters, from baptizing the child after birth until its education ends with a diploma.

> Hence, the seemingly righteous and humanitarian debate on child self-determination and consent in sex is just another game adults play to impose their own values on children. For most of the everyday adult-assigned children's

> activities on which the adults hold no discrepant values, debates on child consent are taken as irrelevant and best to be forgotten for parental convenience.
>
> Yet, for child sexual activity, the debate is raised only because not all adults hold the same value judgment. Despite what the debaters on each side may say, it does not follow that any of them are actually more concerned with children welfare and rights than the others. Both sides are only fishing out and exploiting the children's rights issue to support their own preconceptions or needs on child sexuality.

Paul Okami

strongly agrees with Green. He agrees with Schmidt as far as "Schmidt rightly attempts to distinguish questions of wrongfulness from those of harmfulness. These concepts have become hopelessly entwined in the discourse on pedosexuality".
He also disagrees with Schmidt, but in the other direction from other peer comments. He especially disagrees with the presumption that there always is a power imbalance in contacts between children and adults.

> The problem with the 'balance of power' argument is that dyadic power can be in constant flux within a relationship and, in any event, is always multidimensional. [...]Moreover, there is nothing logically intrinsic in power discrepancy that violates principles of justice or fairness in sexual relationships or that is necessarily harmful to the "less powerful" participant, unless one views sexual relationships as similar to hand-to-hand combat (e.g., heavyweight vs. flyweight contestant).
>
> The instability and multidimensionality of dyadic power and the fact that a "power-balanced" relationship is clearly mythological (in the sense that it can never be logically ascertained) lay to rest as useless the "power imbalance" argument. At best, this argument is a fine example of late twentieth century cultural-feminist silliness.

So, Okami gives another interpretation of Schmidt's example of the electric train playing and the intimacy following it. He sees "straw man arguments" in Schmidt's argument.

Robert Prentky

agrees with Green and criticizes the DSM list. As an example, he speaks about Lewis Carroll, the author of Alice, and James Barrie, author of Peter Pan. Mentally ill people? Surely not. If there must be a criterion for a mental disease, it should be self-control or the lack of it.

Bruce Rind

agrees with Green, but disagrees with Schmidt's moral statements. Rind also refers to the dynamics in the power balance and disagrees that there always should be an imbalance.

> Most objectionable from a scientific and philosophy of logic perspective is Schmidt's willingness to test a universal proposition with a single confirming hypothetical case. Appropriate testing would consist of determining whether disconfirming empirical cases can be found. I provide such cases. [...]
>
> These cases, involving five men who had sex as boys around age 10 with men, dispute Schmidt's claim that there can never be sexual consensus between prepubescents and adults.

Michael Seto

views pedophilia as a disorder, but the DSM has not defined it well. One should not define behavior as an illness. And one should define pedophilia so that it only concerns a sexual desire for sexually still immature *pre*-pubescents.

Robert Spitzer & Jerome Wakefield

criticize Green. They agree that not all pedophile behavior refers to a mental disorder, only some behavior does. But they miss clear definitions in Green's argument. Clear definitions should discriminate between normality and disorders.

Kenneth Zucker,

who, as the Editor of the magazine, has opened the special issue, now, with the "Z" in his name, ends the list of peer commentators by giving the history of the DSM from 1973, the year that homosexuality was removed from the DSM list. However, there are too many differences between homosexuality and pedophilia. Thus, the arguments cannot be the same. One should study how DSM defines a mental disorder and then see if pedophilia fits with this definition or not. Other arguments are irrelevant. The end of the debate is still unsure.

A comment from the reporter

Several peer commentaries reject the cross-cultural argument, by saying "we don't live in Polynesia in a far-off age" or so.
In my view, this seems to me a typical case of Americanism: the ultimate in the (post-)modern Western way of thinking:
'We have found the light of the real truth; other cultures have for ages walked in the darkness of the wrong insights.'
In my opinion, this is not true.

Replies of the authors

Green

starts with the cross-cultural arguments:

> At the outset, thank you to those commentators who added to my list of historical and cross-cultural examples of child-adult sex:

- the child-brides and grooms of China;
- Charles Dodgson (Lewis Carroll), who brought us Alice;
- James Barrie, who brought us Peter Pan;
- Muhammad, who brought us Islam; and
- St. Augustine, who brought us Christianity.

He replies more or less comment by comment, which is too long for this report, but an issue repeating itself is the question of harm. Some comments said: 'because there is always harm, there is always a distortion'. In reply to Spitzer & Wakefield, Green repeats his own words:

> "Consensual same-sex adult-adult sexuality does not suggest the element of harm to one participant ... " and he adds:
> Suggesting the element of harm does not equate with the universal certainty of harm.

In reply to Berlin:

> He correctly states that pedophilia can create both psychological burdens and impairments (as can heterosexuality or homosexuality, I would add) but (like heterosexuality or homosexuality), must it? Why then declare pedophilia a disorder for all?

In reply to several commentators who took up Green's nuance that harm is not always present, and that there are lots of pedophiles who only have their fantasies:

> No harm, no foul.

And in other words, picking up the cross-cultural arguments:

> If a society does not condemn a behavior, more will participate. I do not agree that those who continue to participate when society does condemn are necessarily

> mentally ill. Antisocial behavior may be criminal (it often is), but it need not be a mental illness (it often is not).

Schmidt

acknowledges in his reply that dyadic power is always unstable and multidimensional. He refers to Ng, Okami and Rind who

> "argue that we are upset by this lack of consensus only when sexuality is involved, and this they regard as an ideological reaction. Neither argument can be effectively refuted. Yet, both Okami and Rind fail to make it clear whether their reference to these truisms means that they recognize no special characteristics of child-adult sexual interaction. [..T]hey avoid the central question underlying the debate on pedophilia: Is there anything special about adult-child sex ual relations?"

This is the central question for Schmidt. He is not convinced by Rind's five cases, which he sees as "exceptions" and the seeing of a general trend in these cases "breathtakingly simple and naïve".

Schmidt agrees with the commentators who have rejected the cross-cultural variance as an argument. 'The people of Sambia cannot help us'. So, he does not develop the argument, but he has great respect for these contributions:

> "They sow doubts about positions that have come to be taken for granted in Western societies, and they keep the discussion open in a direction to which too little attention is given today: fairness against pedophiles. And they demonstrate admirable courage."

The reporter looks back

A very good initiative to make this special issue.
We could not expect unanimity, but we have seen reasonable thinking and polite arguing with a lot of subtle differences in approach.
The main recurring points of discussion were:

- (1) The distinction to be made between the different discourses;
- (2) The distinction to be made between the rich variety of pedophile behavior;
- (3) The question of harm, especially inevitable harm;
- (4) The question of whether a deviancy should always be regarded as an illness;
- (5) The validity of the cross-cultural arguments.

[Index Library Two] [Scientific articles] [Newsletter E15]

Sexual Abuse: Signs and Symptoms
Originally placed online by the Harvard med students -- Thank you!

Adams Classification Table, April 2003: Physical and Laboratory Findings

Used with permission of Joyce Adams, MD

Key point to remember in evaluating children and adolescents who may have been sexually abused: **As many as 85-95% of children who give a clear history of sexual abuse may have normal or nonspecific physical examinations, due to healing of trauma or acts that do not result in trauma.**

Female Genitalia	Anus	Penis/Scrotum	Other
Class 1 Normal or Unrelated to Abuse Found in newborns: • Periurethral or vestibular bands • Hymenal tags • Hymenal bump or mound • Linea vestibularis • Hymenal cleft/notch in the anterior (superior) half of the hymenal rim, on or above the 3 o'clock and 9 o'clock line, patient supine • Estrogen changes (i) Normal variants: • Septate hymen • Failure of midline fusion/perineal groove	**Class 1 Normal or Unrelated to Abuse** • Tag at 6 o'clock from redundant perineal raphe • Thickening of perineal raphe • Blue tint from underlying veins Normal variants: • Diastasis ani • Perianal skin tag • Increased perianal skin pigmentation • Anal dilation with stool present • Venous congestion, or venous pooling, in perianal tissues (vi)	**Class 1 Normal or Unrelated to Abuse** • Circle of brown pigment around shaft of penis from healed circumcision • Raised, dark line along penis/scrotum (median raphe)	**Class 1 Not related to abuse:** • Candida infections • Strep infections • Urinary tract infections • Vaginitis caused by enteric or respiratory organisms • Gardnerella vaginalis cultured from vagina, in the absence of any other signs of bacterial vaginosis Also, conditions such as urethral prolapse, lichen sclerosis, genital hemangiomas, Crohn's Disease, and Bechet's Disease may be mistaken for abuse.

Class 2 Nonspecific	**Class 2 Nonspecific**	**Class 2 Nonspecific**	**Class 2 Nonspecific: May be transmitted by sexual or nonsexual means:**
Findings that may be the result of sexual abuse, depending on the timing of the examination with respect to the abuse, but which also may be due to other causes. • Erythema (redness) of the vestibule or increased vascularity ("dilatation of existing blood vessels") of vestibule • Superficial abrasions of the labia or posterior fourchette • Shallow notches in the posterior rim of hymen extending through 50% or less of the width of the hymenal rim • "Narrow" rim of hymen measuring 1-2 mm wide • Labial adhesion • Vaginal discharge • Vesicular lesions or ulcers in the genital area • Genital warts in a child • Blood on underwear • "Vaginal" bleeding (Found in both abused and non-abused children/adolescents) (ii, iii, iv, v, xi)	• Erythema (redness) of the perianal tissues • Anal fissures • Anal dilation without stool visible • Superficial abrasions of the perianal skin • Bruises on the buttocks • Vesicles or ulcers in the anal area or on the buttocks • Bleeding from the anus (ii, iii, iv, v)	• Erythema of penis, lower abdomen or inner thighs • Edema of penis/scrotum (These may result from self-manipulation, poor hygiene, contact irritation/inflammation, or infection) • Superficial abrasions on the penis/scrotum • Warty lesions or vesicular lesions on the penis/scrotum	• Herpes type I or II in a child who requires caretaker assistance with toileting or hygiene, or who may have self-innoculated from an oral lesion • Bacterial vaginosis in a child or adolescent • Any STD (including HPV or genital wards) in an infant who may have acquired it perinatally (vii)

Class 3 Concerning for Abuse	**Class 3 Concerning for Abuse**	**Class 3 Concerning for Abuse**	**Class 3 Concerning for Abuse: Sexual transmission is likely cause of infection:**
Findings that have been noted in children with documented abuse, and may be suspicious for abuse, but for which insufficient data exists to indicate that abuse is the only cause. **Acute trauma - suspect sexual abuse:** • Acute lacerations or bruising of labia, fossa, posterior fourchette or perihymenal tissues • Bruises or bites to upper or inner thighs near genitalia • Sucker/hickey marks on inner thighs near genitalia **Possible healed injuries from abuse:** • Scar of the posterior fourchette • Hymenal notch/cleft extending through more than 50% of the posterior (inferior) or lateral portion of the hymenal rim	**Acute trauma - suspect sexual abuse:** • Marked bruising and edema of the perianal tissues, as distinguished from venous pooling **Possible residual from trauma:** • Perianal scar (may be due to healed fissure from Crohn's Disease or from surgery)	**Acute trauma - suspect physical or sexual abuse:** • Banding of penis with child's hair or other objects (this may be accidental in infants, from hair of a caretaker) • Bite or pinch marks on penis, scrotum, or inner thighs near genitalia • Sucker/hickey marks on inner thighs near genitalia	• Herpes type I or II lesions in the genital area in a child who has no oral lesions and requires no assistance with toileting or hygiene • Trichomonas infection diagnosed by wet mount preparation or culture of vaginal secretions • HPV infection in a child in whom perinatal transmission is considered unlikely (vii)

Class 4 Clear evidence of blunt force or penetrating trauma to or beyond the hymen: Findings that can have no explanation other than trauma to the hymen or vaginal tissues. **Acute trauma:** • Partial or complete tear of the hymen • Ecchymosis (bruising) on the hymen • Vaginal laceration **Healed trauma:** • Hymenal transection (healed), defined as an area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall.(viii) This finding has also been referred to as a "complete cleft" in adolescent and young adult women.(x) • Wide areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissue, extending to the base of the hymen, which is confirmed using additional examination technique (swab, Foley catheter,	**Class 4 Clear evidence penetration beyond the anal sphincter:** • Perianal lacerations extending deep to the external anal sphincter (ix)		**Class 4 Clear Evidence: Sexual abuse/contact is certain:** • Pregnancy • Sperm or semen found in or on child's body • Video or photo documentation of child being abused • Confirmed positive genital, anal or pharyngeal cultures for Neisseria gonorrhea • Positive cultures (not rapid antigen tests) from genital or anal area for Chlamydia trachomitis • Positive serology for syphilis or HIV, if perinatal or blood transmission has been ruled out (vii)

prone knee-chest position).			

This table was developed from multiple sources, including published classification scales authored by David Muram, MD and Joyce Adams, MD. Penis and scrotum classification and "other" by Charles Johnson, MD.

Adapted from:
Muram D. Classification of genital findings in prepubertal girls who are victims of sexual abuse. Adolesc Pediatr Gynecol 1988; 1:151.
Adams JA. Evolution of a classification scale: Medical evaluation of suspected child sexual abuse. Child Maltreatment 2001;6:31-36.
Johnson CF. Is it normal or not? SCAN 2001;13:4-5.

Top

Psychosocial Indicators of Sexual Abuse

The following factors may influence the intensity and type of reaction a child has to the experience of sexual abuse (although some important issues related to any one child's experience may not be included in this list):

- Identity of perpetrator
- Child's age
- Child's developmental status, including whether or not the child has any developmental disabilities
- History of prior, or concurrent maltreatment, trauma or stress
- Relationship with alleged perpetrator
- Duration (time span) of the abuse
- Circumstances/context of the abuse (i.e. has the child been afraid, embarrassed, etc?)
- Type and intensity of abuse or neglect
- Family, social and community support
- Child's coping strategies, and generality personal characteristics (i.e. temperament)

A child's reactions may involve behaviors that can be observed by other people, or may simply involve

the child's innermost thoughts and/or subjective emotional feelings. Some of the reactions to sexual abuse can be similar across age groups, while other reactions may be more common in younger or in older children. In general, it may be difficult to differentiate children who have been sexually abused from children who have experienced other kinds of stressful experiences. It is important to remember that research in the area of child maltreatment suggests that many abused children do not exhibit any obvious reactions to sexual abuse. Therefore, if a child is not exhibiting concerning behaviors, but you have reason to suspect sexual abuse (for instance, if the child has been exposed to a known sexual offender), it is strongly recommended that you consult a professional with expertise in the area of child maltreatment for guidance.

The following list includes general signs and symptoms that may sometimes be observed in sexually abused children. When reviewing this list, it is very important to remember that fears and behavioral difficulties are commonly associated with normal child development. Many of the following are concerning only when behavioral changes are extreme or occur suddenly. If you have concerns, it is often helpful to consult a professional with expertise in this area.

Sexualized Behaviors

While there is no one symptom which is diagnostic of sexual abuse, with the exception of pregnancy or a sexually transmitted disease in a non-sexually active child or adolescent, the literature indicates that the symptoms most commonly associated with sexual abuse are sexualized behaviors, particularly trying to engage other children in sexual behaviors, and indicators of age-inappropriate sexual knowledge. However, it is extremely important to understand that many children who have been sexually abused do not exhibit sexualized behaviors. It is equally important to understand that children who have never been sexually abused may exhibit sexual behaviors.(4)

Risk Factors for Sexualized Behaviors
As a general comment, it is important to note that there are numerous factors that may be associated with age-inappropriate acting out sexually. The following life circumstances are thought to increase the risk of children engaging in inappropriate sexual behaviors:

- Sexual abuse
- Exposure to individuals (adults, adolescents or other children) known to have committed prior sexual offenses
- Living in a highly sexualized/over-stimulating atmosphere where personal boundaries are lacking
- Exposure to adult/adolescent sexual intimacy
- Exposure to sexually explicit materials including printed materials, videotapes, or pornography
- Living with needy adults who may turn to children to meet their emotional needs or unmet needs for affection

Function of Sexualized Behaviors
The function of sexualized behaviors varies from child to child. Sexualized behaviors are thought to serve the following functions:

- To decrease a child's anxiety, fear or overall distress; to reduce tension or other unpleasant internal sensations
- To retaliate or hurt others
- To reflect re-experiencing behaviors consistent with reactions often noted in children who have been sexually abused
- To elicit an intense reaction from other children or adults
- To be motivated by needs of attention or power.
- To reflect natural curiosity at times, but be misinterpreted on occasion as deviant

Sometimes sexual behaviors in children may actually be age-appropriate and likely contribute to normal and healthy sexual development. Sometimes children may not understand social expectations, or that the sexualized behaviors are socially unacceptable.

Distinguishing Worrisome from Healthy Sexual Behaviors
A number of authors have written about sexualized behaviors in children. Friedrich has done considerable research in this area and has begun to identify which sexual behaviors are most likely to occur in boys and girls of different ages.(5) For instance, touching sexual parts (private parts) at home is common for most children and usually not a worrisome behavior.

Toni Cavanaugh Johnson has identified characteristics that can help a parent or adult figure out if a sexual behavior is cause for concern or is simply a normal part of growing up.(6) However, even if you think that a behavior is normal and unrelated to sexual abuse, it is often helpful to discuss the behaviors with a professional who has expertise in this area if you have any concerns.

The following information has been adapted from the work of Toni Cavanaugh Johnson regarding *Natural and Healthy Sexual Behaviors* exhibited by children. It is her view that sexualized behaviors classified as natural and healthy represent an information gathering process. It is important to note that children engaging in normative sexual behaviors are:

- of similar age, size and/or developmental status
- engaged in mutual sexual exploration
- likely to display a lighthearted emotional expression

Of further note is that the sexual behavior is:

- limited in time and frequency
- balanced by curiosity about other aspects of his/her life
- may result in embarrassment when discovered by someone else

- ceases (in the presence of adults) when children are instructed to stop engaging in the behaviors

Dr. Johnson has also identified *Problematic Sexual Behaviors* in children. The list that follows is not exhaustive which means that other characteristics that are not included on the list can also be worrisome. Even worrisome behaviors do not mean that a child has been sexually abused. However, if you are concerned about a child's sexual behavior, it is often a good idea to consult a professional with expertise in this area. The following sexualized behaviors are thought to be problematic:

- Sexual behaviors engaged in by children of different ages and/or developmental levels
- Sexual behaviors which are significantly different than those of same age peers
- Sexual behaviors that progress in frequency, intensity and intrusiveness over time
- Sexual behaviors that include animals
- Sexual behaviors that are intended to inflict pain or hurt others
- Sexual behaviors that have been coerced by other children by the use of force, bribery, manipulation or threats
- Sexual behaviors that cause children to react with fear, anxiety, shame or guilt

Psychosocial Indicators of Sexual Abuse

Nonspecific Behaviors

Sexually abused children may exhibit a range of emotional or behavioral problems as a result of their abuse experience. The type and degree of disturbance varies from child to child ranging from no obvious reaction to very mild reactions to extreme behavior changes. According to one published article, up to 40% of sexually abused children are asymptomatic.(4) This means that no symptoms or concerning behaviors were observed. It is important to note that no single symptom or behavioral profile can distinguish a maltreated child from his/her age-mates who have not been maltreated. Most of the behaviors exhibited by abused or neglected children are often associated with non-abuse related difficulties or other types of trauma experienced by children. Of the behaviors that may be seen in sexually abused children, most are also linked to extreme stress reactions in children and/or general child trauma. That means that a child's behavioral changes can cause concern and be quite alarming because he or she has been sexually abused, but can also be caused by circumstances completely unrelated to child abuse.

The following behaviors are sometimes be seen in sexually children. They are significant when they occur in conjunction with a child's disclosure and/or if the child has been exposed to a known sexual offender. These symptoms and behaviors in and of themselves do not necessarily indicate sexual abuse, but may be indicative of some other problem or trauma.

Behavioral Reactions:

- Sleep distiurbances: night terrors; nightmares; trouble falling asleep; trouble staying asleep or sleeping alone.
- Changes in eating habits: compulsive or overeating; loss of appetite
- Changes in toileting habits including urinary or bowel accidents
- Increased aggression: directed toward self (including suicide attempts) or others
- Increased impulsivity and activity
- Academic problems: distractibility, concentration problems, lack of focus
- Reluctance or refusal to go home or to other environments
- Easily startled; seems to be tense quite often; difficulty relaxing and calming down
- Unexplained fears of, or avoidance of, specific individuals, places, objects or situations
- Separation anxieties: clinginess, school refusal
- Negative statements about oneself; a negative or pessimistic outlook
- Low energy
- Social withdrawal
- Somatic/medical complaints: commonly include gastrointestinal complaints, headaches, pain and general physical malaise
- Antisocial acts, such as hurting animals, setting fires and stealing
- Running away from home

Cognitive Reactions:

- Inattentiveness
- Disorientation
- Daydreaming and fantasizing
- Negative thoughts about oneself, related to low self-esteem, guilt embarrassment and self-blame
- Pessimism regarding the future and/or a difficulty imagining oneself in the future
- Forgetfulness

Emotional Reactions:

Some emotional reactions can be associated with the behavioral and cognitive reactions described above, as well as physiological changes that are more difficult to observe (e.g., increased heart rate). Children who have been sexually abused or otherwise exposed to extreme stress are often described as anxious, depressed, or as labile (having unusually strong mood swings) and they may have difficulty calming down or soothing themselves when they are upset. They can also appear to be very needy of adult attention, fearful of inciting adult displeasure, and/or unusually suspicious or fearful in situations that might not cause discomfort in others.

Psychosocial Indicators of Sexual Abuse

Top

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CHILD MALTREATMENT
MEDICO-LEGAL TERMINOLOGY AND
INTERPRETATION OF MEDICAL FINDINGS

A Consensus of Medical and Legal Child Abuse Practitioners in the Philippines

Second Edition

Manila, Philippines 2002

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In cooperation with the Child Protection Unit Network and the Advisory Board Foundation, Manila

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The American Professional Society on the Abuse of Children

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INTRODUCTION

Since signing the United Nations Convention on the Rights of the Child, the Philippines has strengthened its efforts in enforcing the rights of all children, increasing public awareness of child abuse, and creating programs for maltreated children. As a result, the Philippines observed a dramatic increase in the number of reported cases of maltreatment and, consequently, a rise in the number of court hearings for perpetrators of child abuse.

For many of these hearings, it is the interview of the child and the findings of the physician performing the medico-legal examination that may determine the outcome of a case. Given the importance placed upon the physician's findings and testimony, as well as the difficulty involved in interpreting this evidence, it becomes all the more important to standardize the terminology utilized by physicians for describing child maltreatment so that it can be understood by judges, lawyers and any other professionals involved in child abuse cases.

Beginning in 2000, a technical working group – comprised of lawyers, judges and physicians from the National Bureau of Investigation's Medico-Legal Division and Violence Against Women and Children Division (VAWCD), the Philippine National Police Crime Laboratory and Women's Crisis and Child Protection Center (WCCPC), the Philippine General Hospital Child Protection Unit (PGH-CPU) and the Department of Health – came together to examine the vocabulary used by child protection physicians throughout the world. Culling through various terms, the working group agreed upon a comprehensive and up-to-date child protection lexicon, and finalized the definitions for ambiguous terms. The working group then devised a common medical certificate that can be utilized by physicians of child protection units, the Department of Health, the National Bureau of Investigation, the Philippine National Police, or other public and private medical institutions, and that will be recognized by judges and legal professionals across the country.

Notably, the Philippines will be the first country in the world to incorporate a uniform medico-legal terminology and certificate into its national child protection system.

OUR GOALS

It is the genuine hope of the authors that, after reading this publication, users will have reaped the following benefits:

- ***Improved technical understanding:*** By becoming more familiar with the child protection medical terminology and examination, members of the medical and legal community will have a stronger grasp of the information contained within the medico-legal certificate, reducing the possibility of misinterpretation.

- ***Ability to "speak the same language":*** Child abuse occurs globally; hence, physicians must share a single vocabulary so as to better communicate ideas and best practices worldwide.

- ***Standardized procedures:*** The standardization of terminology and the certificate itself may lead to standardized procedures. If one comprehensive examination can be created and agreed upon by all members of the medico-legal community, there will be less cause for multiple exams and, thus, less possibility of re-traumatizing patients.

Ultimately, it is our intention that this publication will serve as both an educational tool for child protection professionals unfamiliar with the medico-legal examination, and as a guideline for those in the medical community actually performing the examination. Please note that this manual is not intended to be a substitute for actual child protection specialist training.

HOW TO USE THIS GUIDE

This publication serves as a supplement to the standardized medico-legal certificate. On the following pages, the certificate will be dissected and explained in detail in order to clarify any areas of confusion and, ultimately, to facilitate its use by physicians and members of the legal community. Each section and subsection of the certificate is illustrated, complete with brief instructions for proper completion of that section. When further explanation is required, more detailed information is provided on the page, below the relevant section.

The diagnosis of sexual abuse should not be based solely on the physical examination. In addition to the medico-legal exam, diagnosis depends heavily upon the results of the patient interview, behavioral assessment and laboratory tests.

Further, medical evidence is only one component of the overall criminal investigation of child abuse cases; other aspects such as crime scene investigation and witness corroboration by law enforcement investigators, and home visits conducted by social workers, are equally as important.

MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
PATIENT'S NAME		AGE		DOB		SEX	
PATIENT'S ADDRESS							
CIVIL STATUS		OCCUPATION		NATIONALITY			
REQUESTING PARTY		PLACE, TIME AND DATE OF EXAMINATION					
❑ Acute Evidentiary Examination (within 72 Hours of incident)			❑ Non-Acute Examination				

FINDINGS			
GENERAL PHYSICAL FINDINGS			
HEIGHT		WEIGHT	
GENERAL SURVEY			
MENTAL STATUS			
PERTINENT PHYSICAL FINDINGS/ PHYSICAL INJURIES			
ANO-GENITAL EXAMINATION			
EXTERNAL GENITALIA			
URETHRA AND PERIURETHRAL AREA			
PERIHYMENAL AREA AND FOSSA NAVICULARIS			
HYMEN			
PERINEUM			
DISCHARGE			
INTERNAL AND SPECULUM EXAMS			
ANAL EXAMINATION			
DIAGNOSTICS AND EVIDENCE GATHERING			
FORENSIC EVIDENCE AND LABORATORY RESULTS			

IMPRESSIONS

DEMOGRAPHIC DATA

DEMOGRAPHIC DATA							
PATIENT'S NAME		AGE		DOB		SEX	
PATIENT'S ADDRESS[1]							
CIVIL STATUS		OCCUPATION[2]		NATIONALITY			
REQUESTING PARTY[3]		PLACE, TIME AND DATE OF EXAMINATION					
❑ Acute Evidentiary Examination (within 72 Hours of incident)			❑ Non-Acute Examination				

1. Patient's Address
The address used on this form is typically the location where the subpoena will be served; consequently, the address must be current. If the child is placed in a shelter, the shelter's address should be listed.

2. Occupation
As these forms may also be used for adult patients treated in WCPUs, occupation is included as an option. When the patient is a child, leave the space blank.

3. Requesting Party
When filling in the requesting party, insert the agency or individual referring the patient.
For example:

- The organization listed in the letter of request accompanying the patient
- If no referring agency, the individual who signed the consent for the patient (and his or her relationship to the patient)

GENERAL PHYSICAL EXAMINATION: GENERAL SURVEY

GENERAL PHYSICAL EXAMINATION			
HEIGHT		WEIGHT	
GENERAL SURVEY	*Include if possible:* ❑ **Nutritional status (optional)**[4] ❑ **Ambulant/non-ambulant** ❑ **Respiratory distress/not in respiratory distress** ❑ **Other comments (e.g. hygiene)**		
MENTAL STATUS			
PERTINENT PHYSICAL FINDINGS/PHYSICAL INJURIES			

4. Nutritional Status

If desired, the physician may determine the child's nutritional status using stunting and wasting calculations, such as those found below.

Stunting

a. Get ideal height (P50) for age using height table or growth charts

b. Compute proportion: $\left(\frac{\text{Actual height}}{\text{Ideal height for age}}\right) \times 100$

c. Interpretation:

- **No stunting**: if actual height is 90% of ideal height
- **Mild stunting**: if actual height is 80-89% of ideal height
- **Moderate stunting**: if actual height is 70-79% of ideal height
- **Severe stunting**: if actual height is less than 70% of ideal height

Wasting

a. Get ideal weight (P50) for age using weight table or growth charts

b. Compute proportion: $\left(\frac{\text{Actual weight}}{\text{Ideal weight for height}}\right) \times 100$

c. Interpretation:

- **No wasting**: if actual weight is greater than 95% of ideal weight for height
- **Mild wasting**: if actual weight is 87.5% to 95% of ideal weight for height
- **Moderate wasting**: if actual weight is 80% to 87.5% of ideal weight for height
- **Severe wasting**: if actual weight is less than 80% of ideal weight for height

GENERAL PHYSICAL EXAMINATION: MENTAL STATUS

GENERAL PHYSICAL EXAMINATION			
HEIGHT		WEIGHT	
GENERAL SURVEY	*Include if possible:* ❑ Nutritional status (optional) ❑ Ambulant/non-ambulant ❑ Respiratory distress/not in respiratory distress ❑ Other comments		
MENTAL STATUS	***Include if possible:*** ❑ **Orientation as to time, place, person[5]** ❑ **Consciousness, demeanor[6]** ❑ **Developmental delay or mental retardation?[7]**		
PERTINENT PHYSICAL FINDINGS/PHYSICAL INJURIES			

5. Orientation as to Time, Place, Person
Some children are obviously too young to be "oriented"; in these situations, simply describe the patient's level of awareness (e.g., awake, asleep but arousable, alert, etc.).

6. Consciousness, Demeanor
Describe what the patient is doing while under observation (e.g., playing, crying but consoled by mother, sitting quietly, etc.). For older children and adolescents, note indicators of demeanor, including blank staring or a depressed appearance.

7. Developmental Delay or Mental Retardation
Examining physicians who are not developmental specialists may still include general observations concerning a patient's mental status. In cases of suspected developmental delay or mental retardation, physicians should indicate that their observations serve as estimations only and that the patient will be referred to a psychiatrist, psychologist or developmental pediatrician for assessment.

GENERAL PHYSICAL EXAMINATION: PERTINENT PHYSICAL FINDINGS/ PHYSICAL INJURIES

GENERAL PHYSICAL EXAMINATION			
HEIGHT		WEIGHT	
GENERAL SURVEY	*Include if possible:* ❑ Nutritional status (optional) ❑ Ambulant/non-ambulant ❑ Respiratory distress/not in respiratory distress ❑ Other comments		
MENTAL STATUS	*Include if possible:* ❑ Orientation as to time, place, person ❑ Consciousness, demeanor ❑ Developmental delay or mental retardation?		
PERTINENT PHYSICAL FINDINGS/PHYSICAL INJURIES	***Include if possible:*** ❑ **Injuries on the body[8]** ❑ **Description of breasts[9]** ❑ **Pregnancy-related findings** ❑ **Other abnormalities**		

8. Injuries

Contrary to commonly held beliefs, the exact time of a bruise's infliction cannot be determined accurately based on appearance. All that can be definitely stated is that if the color of the bruise is **yellow**, the injury did not occur within the last 18 hours. Other colors may appear at any time from within one hour of injury to resolution of the bruise, and so cannot be used to accurately date the age of bruises. Further, bruises of identical age and cause on the same patient may vary in appearance and change colors at different rates.

9. Description of Breasts

If the patient is female, describe her breasts according to the following categories:

Nipple
- Color (e.g., pink, light brown, dark brown, darkly pigmented/ hyper-pigmented)
- Inverted, flat, protruding
- Physical injury (if any)

Areola
- Color
- Breast budding
- Physical injury (if any)

Breast Tissue
- Prepubertal
- Developing
- Mature female breast

GENERAL PHYSICAL EXAMINATION: PERTINENT PHYSICAL FINDINGS/ PHYSICAL INJURIES - *continued*

GENERAL PHYSICAL EXAMINATION			
HEIGHT		WEIGHT	
GENERAL SURVEY	*Include if possible:* ❑ Nutritional status (optional) ❑ Ambulant/non-ambulant ❑ Respiratory distress/not in respiratory distress ❑ Other comments		
MENTAL STATUS	*Include if possible:* ❑ Orientation as to time, place, person ❑ Consciousness, demeanor ❑ Developmental delay or mental retardation?		
PERTINENT PHYSICAL FINDINGS/PHYSICAL INJURIES	***Include if possible:*** ❑ **Injuries on the body** ❑ **Description of breasts** ❑ **Pregnancy-related findings[10]** ❑ **Other abnormalities**		

10. Pregnancy-Related Findings

If the patient is pregnant, evaluate the pregnancy according to the following criteria:

- Enlarged abdomen (measure fundic height)
- Presence of fetal heart tone (FHT) (record rate and location)
- Presence of fetal movement
- Gravity
- Parity
- Date of last menstruation

Example: abdomen globularly enlarged with FHT heard in right lower quadrant, and fetal movement appreciated in left lower quadrant.

Estimation of the age of gestation may be based on the following:

- Date of last menstruation
- Onset of fetal movement
- Fundic height
- Ultrasound results

Pregnancy tests and their results should be recorded under the section "Diagnostics and Evidence Gathering."

ANO-GENITAL EXAMINATION: EXTERNAL GENITALIA

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ **Describe pubic hair of patient[11]** ❑ **Description of genitalia: injury/no evident injury at the time of examination**
URETHRA AND PERIURETHRAL AREA	
PERIHYMENAL AREA AND FOSSA NAVICULARIS	
HYMEN	
PERINEUM	
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	

11. Pubic Hair

Describe the appearance and the amount of pubic hair. Suggested descriptions include:

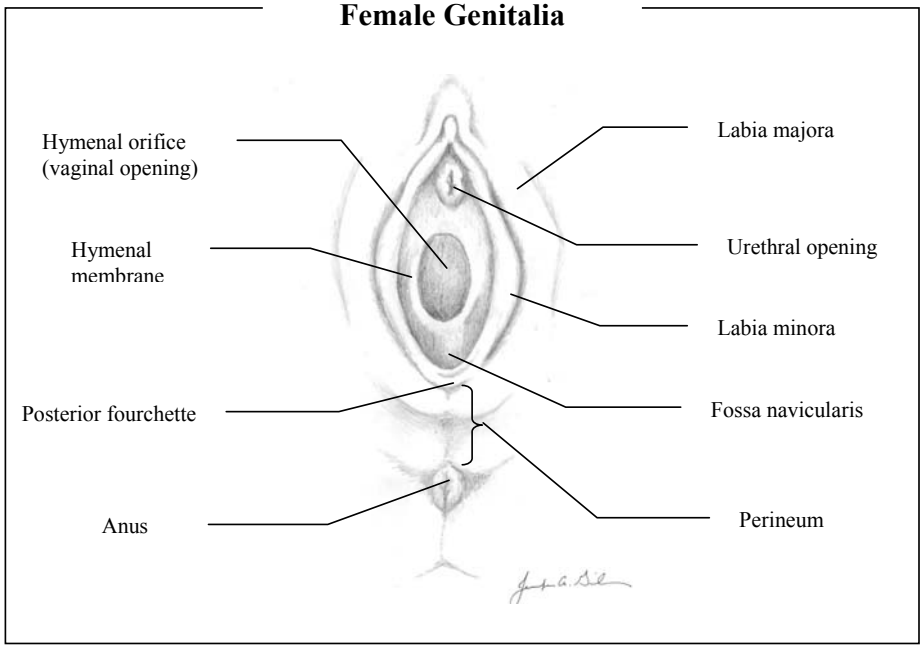
- "No pubic hair"
- "Sparse, pigmented, straight, found mainly along labia or at base of penis"
- "Darker, coarser, curlier"
- "Adult, but decreased distribution"
- "Adult in both quantity and hair-type, with spread to medial thighs"

ANO-GENITAL EXAMINATION: EXTERNAL GENITALIA - *continued*

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ **Describe pubic hair of patient** ❑ **Description of genitalia: injury/no evident injury at the time of examination[12]**
URETHRA AND PERIURETHRAL AREA	
PERIHYMENAL AREA AND FOSSA NAVICULARIS	
HYMEN	
PERINEUM	
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	

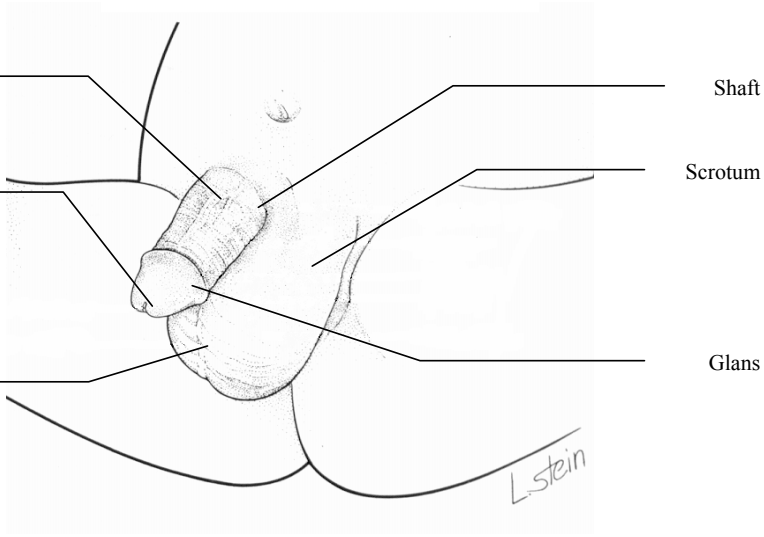
12. Description of Genitalia

For both female and male patients, all parts of the external genitalia should be described, as suggested below and on the following page. If no injury is observed, include a statement to that effect, such as "No evident injury at the time of examination."



ANO-GENITAL EXAMINATION: EXTERNAL GENITALIA - *continued*

MALE EXTERNAL GENITALIA



ANO-GENITAL EXAMINATION: URETHRA AND PERIURETHRAL AREA, PERIHYMENAL AREA AND FOSSA NAVICULARIS, AND PERINEUM

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ **Injury/no evident injury at the time of examination (if injury, please describe injury type[13], location and measurements)**
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ **Injury/no evident injury at the time of examination (if injury, please describe injury type[13], location and measurements)**
HYMEN	
PERINEUM	❑ **Injury/no evident injury at the time of examination (if injury, please describe injury type[13], location and measurements)**
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	

13. Injury Types
Possible injury types are listed below.

- **Abrasion** – Area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process
- **Ecchymosis or bruise** – Hemorrhagic area on the skin due to extravasation of blood into the skin or a mucous membrane
- **Hematoma** – Mass of usual clotted blood that forms in a tissue, organ or body space as a result of a broken blood vessel
- **Laceration** – Injury or tear of tissue

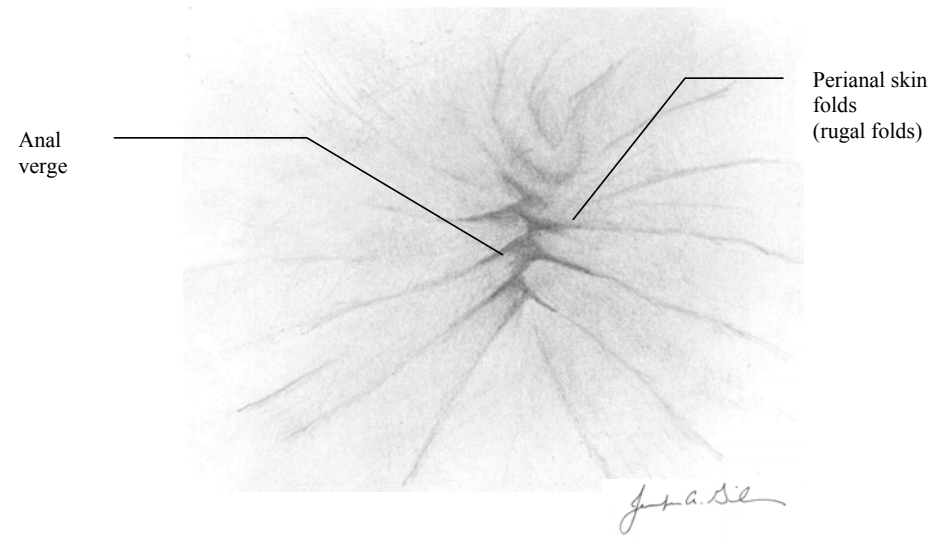
ANO-GENITAL EXAMINATION: ANAL EXAMINATION

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ Injury/no evident injury at the time of examination (if injury, please describe injury type, location and measurements)
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ Injury/no evident injury at the time of examination (if injury, please describe injury type, location and measurements)
HYMEN	
PERINEUM	❑ Injury/no evident injury at the time of examination (if injury, please describe injury type, location and measurements)
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	❑ **Injury/no evident injury at the time of examination (if injury, please describe injury type, location and measurements)[14]**

14. Anal Examination

The conduct of anal examinations will now be considered standard operating procedure in medical examinations evaluating child abuse. Each injury must be described, including its location.

ANUS



ANO-GENITAL EXAMINATION: HYMEN

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ Injury/no evident injury at the time of examination
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ Injury/no evident injury at the time of examination
HYMEN	❑ **Describe shape and appearance**[15] ❑ **Describe injury at the time of examination**
PERINEUM	❑ Injury/no evident injury at the time of examination
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	❑ Injury/no evident injury at the time of examination (describe location)

15. Hymen Shape and Appearance

Describe the shape of the hymen using the characteristics below. Also, describe the thickness and the degree of estrogenization of the hymen.

Shape:
- Annular
- Crescentic
- Cribriform
- Imperforate
- Septate

Thickness and Estrogenization:
- Thin
- Beginning estrogenization
- Estrogenized

Normal Variants (including):
- Hymenal cyst
- Mound
- Rolled edges
- Septal remnant
- Superficial notch

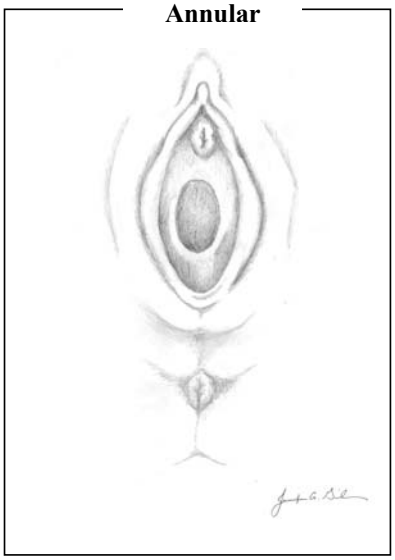
No measurement of hymenal opening will be performed during the medico-legal examination. Studies have demonstrated that hymenal opening measurements in the evaluation of child sexual abuse are limited in their usefulness; measurements vary with the child's position or state of relaxation, or the techniques used to obtain measurements (Berenson, et al., 2002).

In *People v. Baring, Jr.* (GR No. 137933, January 28, 2002), the Supreme Court of the Philippines declared, "The insertion of a finger or any foreign matter inside the hymenal opening under the pretext of determining abuse is unnecessary and inappropriate." The Court further stressed that "the value of collecting evidence should always be weighed against the emotional cost of the procedure and examination of the child."

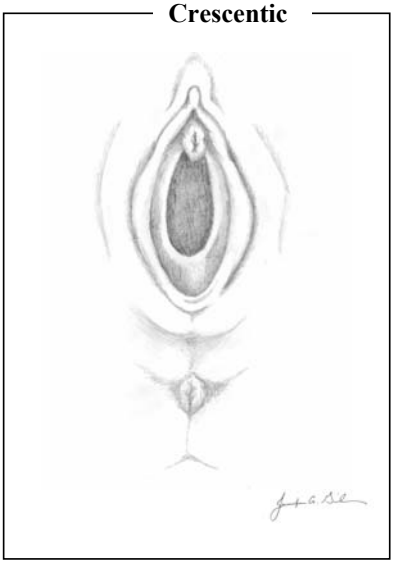
ANO-GENITAL EXAMINATION: HYMEN - *continued*

15. Hymen Shape and Appearance – continued.

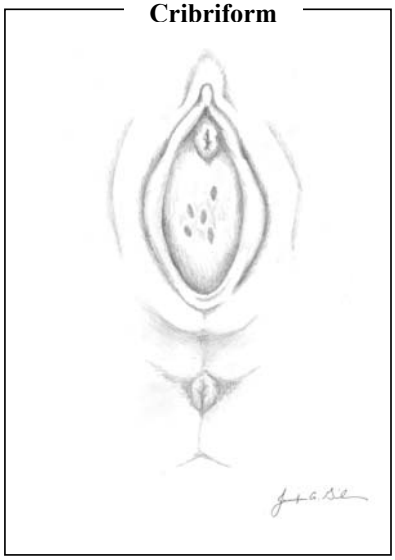
Annular



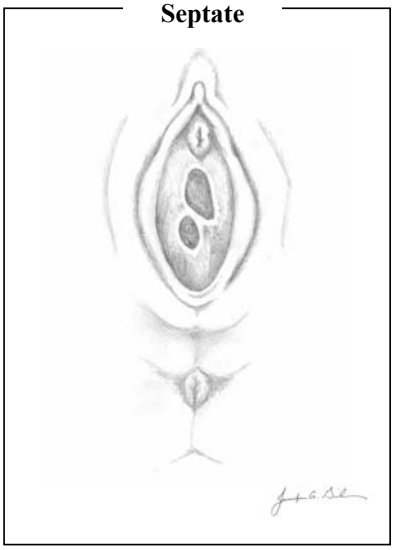
Crescentic



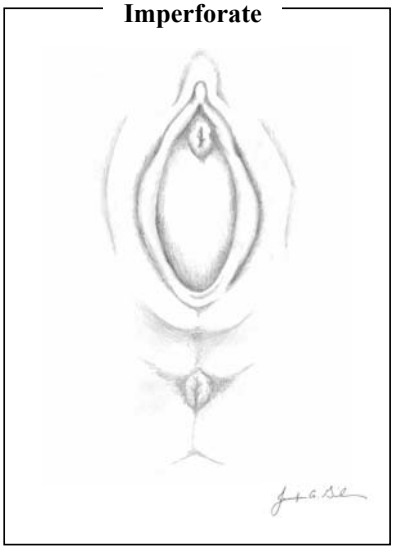
Cribriform



Septate



Imperforate



ANO-GENITAL EXAMINATION: HYMEN – *continued*

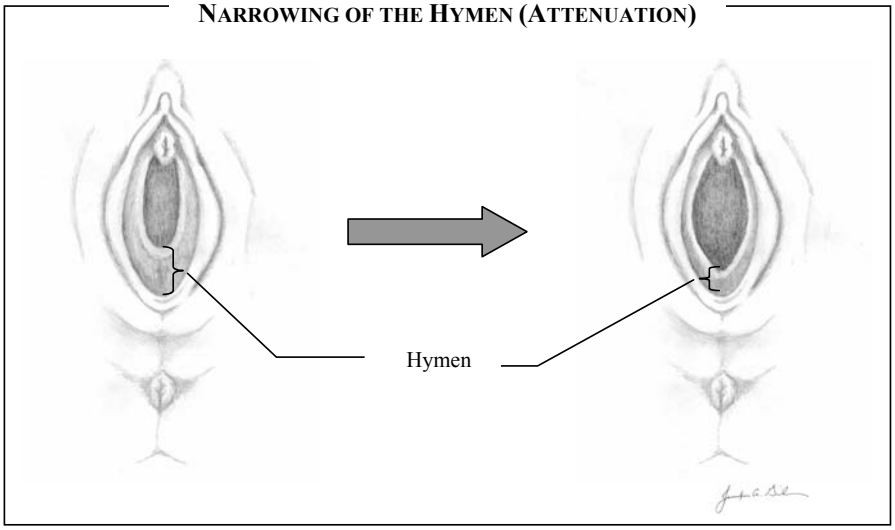
ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ Injury/no evident injury at the time of examination
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ Injury/no evident injury at the time of examination
HYMEN	❑ **Describe shape and appearance** ❑ **Describe injury at the time of examination**[16]
PERINEUM	❑ Injury/no evident injury at the time of examination
DISCHARGE	
INTERNAL AND SPECULUM EXAMS	
ANAL EXAMINATION	❑ Injury/no evident injury at the time of examination (describe location)

16. Hymen Injury

Describe the injury, as well as the location of injury, at the time of examination. Possible injury categories include:

- **Abrasion** – Area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process
- **Attenuation** – Narrowing of the hymen (*Note: this term should be restricted to indicate a documented change in the width of the posterior portion of the hymen following an injury*)

NARROWING OF THE HYMEN (ATTENUATION)

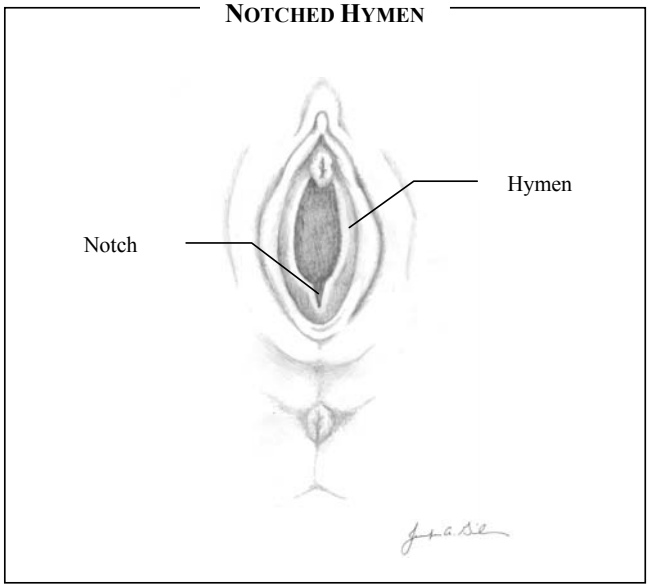


ANO-GENITAL EXAMINATION: HYMEN – *continued*

16. Hymen Injury – continued.

- **Ecchymosis or bruise** – Hemorrhagic area on the hymen due to extravasation of blood into a mucous membrane
- **Hematoma** – Mass of usual clotted blood that forms in a tissue, organ or body space as a result of a broken blood vessel
- **Laceration** – Injury or tear of tissue.
    - Healing time is affected by a variety of factors, including age, nutrition, individual healing capacity and the extent of the wound. Descriptions, such as those listed below, serve as guidelines only; they are not intended to be definitive measurements.
        - **Fresh (presence of fresh blood, edema):** injury occurred within past 24 hours
        - **Healing (presence of granulation, no blood):** injury occurred between 48 hours and 21 days
        - **Healed (with scar):** injury cannot be dated accurately
- **Notch** – Angular or "V"-shaped indentation on the edge of the hymenal membrane and may extend to the muscular attachment of the hymen
    - If notch is greater than 50 percent of the hymen's diameter and is present in the knee-chest postion, classify as ***"suggestive of abuse"***
- **Transection** – Tear or laceration through the entire width of the hymenal membrane

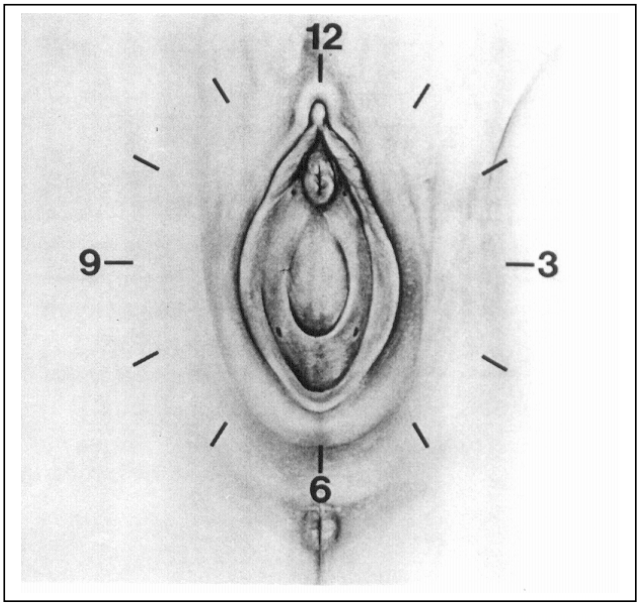
NOTCHED HYMEN



ANO-GENITAL EXAMINATION: HYMEN – *continued*

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ Injury/no evident injury at the time of examination
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ Injury/no evident injury at the time of examination
HYMEN	❑ **Describe shape and appearance** ❑ **Describe injury at the time of examination**[16]
PERINEUM	❑ Injury/no evident injury at the time of examination
DISCHARGE	
IE AND SPECULUM EXAM	
ANAL EXAMINATION	❑ Injury/no evident injury at the time of examination (describe location)

16. Hymen Injury – continued.
When describing the location of injury on the hymen, use the "clock position reference," a method by which the location of a structure may be designated using the numerals on the face of a clock. The 12 o'clock position is always superior (up). The 6 o'clock position is always inferior (down). The position of the patient must be indicated when using this designation.



ANO-GENITAL EXAMINATION: DISCHARGE, INTERNAL AND SPECULUM EXAMS

ANO-GENITAL EXAMINATION	
EXTERNAL GENITALIA	❑ Description of genitalia: injury/no evident injury at the time of examination
URETHRA AND PERIURETHRAL AREA	❑ Injury/no evident injury at the time of examination
PERIHYMENAL AREA AND FOSSA NAVICULARIS	❑ Injury/no evident injury at the time of examination
HYMEN	❑ Describe shape and appearance ❑ Describe injury at the time of examination
PERINEUM	❑ Injury/no evident injury at the time of examination
DISCHARGE	❑ **Present/absent** ❑ **Description**[17]
IE AND SPECULUM EXAM	❑ **Refer to protocol**[18]
ANAL EXAMINATION	❑ Injury/no evident injury at the time of examination (describe location)

17. Discharge

Any discharge found should be described according to the following categories:

Amount	**Odor**	**Color**	**Consistency**	**Other**
• Minimal	• Odorless	• Clear	• Watery	• No blood present
• Moderate	• Fishy	• Whitish	• Mucoid	• Blood-tinged
• Profuse	• Chlorox	• Yellowish	• Pasty	• Bloody
• Oozing	• Foul smelling	• Greenish		

18. Internal and Speculum Exam Protocol

If the patient is not yet an adolescent, internal and speculum exams are not required unless the indications listed below are noted; in these instances, the internal examination should be performed under general anesthesia.

- Suspicion of foreign body in vaginal canal
- Profuse vaginal bleeding (suggesting probable internal injury)

DIAGNOSTICS AND EVIDENCE GATHERING	
FORENSIC EVIDENCE AND LABORATORY RESULTS	❑ **List specimens submitted**[19] ❑ **List lab exams performed and indicate pending lab result**[20]

19. Submitted Specimens

All specimens submitted must be properly labeled. The label should include the following information:

- Date
- Case number
- Patient's name
- Age of patient
- Physician's initials

20. Laboratory Exams

The following are possible laboratory exams to be performed when evaluating a child abuse patient:

- **Swab for presence of semen** for cases occurring within 72 hours (Swab mouth, vagina, rectum and any other site on the body suspicious for abuse)
- **Microscopic examination of vaginal swabs/TMG**
  - **T**richomonas (exam is wet mount)
  - **M**onilia (exam is KOH prep)
  - **G**ram stain
- **Culture** for gonorrhea and chlamydia when resources are available
  - Cervical swabs
  - Oral swabs
  - Rectal swabs
  - Urethral swabs
  - Vaginal swabs
- **DNA analysis** when resources are available
- **Test for presence of drugs and alcohol** when resources are available
- **Pregnancy test/ultrasound** when resources are available
- **Blood test for sexually transmitted diseases** (e.g., VDRL, Hepatitis B, HIV) when resources are available

IMPRESSIONS

IMPRESSIONS
❑ **Record overall impressions in this space[21]**

21. Recording Impressions
Use the Impressions Section of the medical certificate to present an overall conclusion of findings, as well as your assessment of the compatibility of your findings with the allegations of abuse. When formulating an impression, consider all available information:

- Disclosure of abuse or witnessed abuse
- Physical findings
- Behavior changes
- Medical history
- Pregnancy
- STDs
- Forensic evidence (e.g., presence of sperm, results of DNA studies)

All of this information may not be present at the time of examination; in many situations, only physical examination findings are available. It is important to recognize the limits of interpretation of findings if only the physical results are considered.

Further, there may be situations in which the initial examining physician has little knowledge or experience in the evaluation of cases of suspected child abuse. In such circumstances, the following text or a similar variation may be used:

"The interpretation of the evaluation and physical findings is deferred for later review with expert consultation."

Whenever the hymen and hymenal tissues are described, physicians are urged to be as specific as possible concerning the character and appearance of the hymen. Physicians must avoid inaccurate and non-descriptive terms, such as "virgin," "virgin-state" and "intact hymen" (Finkel, et al., 2001). Terms used must be scientifically supported, in accordance with presently accepted international standards such as those endorsed by the American Professional Society on the Abuse of Children (APSAC) and the International Society for the Prevention of Child Abuse and Neglect (ISPCAN).

Medical findings can then be categorized and interpreted using accepted classification systems such as the Adams Classification System for Assessing Physical, Laboratory, and Historical Information in Suspected Child Sexual Abuse (Adams, 2001). As a matter of consensus, this is the classification adopted by this Technical Working Group. Given a set of findings, the suggested wordings of the impressions are presented below and on the following pages. (Refer to Appendix B for the complete Adams Classification System)

Impression: "Medical evaluation shows definite evidence of abuse or sexual contact."

If medical findings or combination of available information are any of the following listed below,
use the above phrase in the Impressions.

1. **Clear evidence of blunt force or penetrating trauma:**

   - Laceration of the hymen, acute
   - Ecchymosis (bruising) on the hymen
   - Perianal lacerations extending deep to the external anal sphincter
   - Hymenal transection (healed): an area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall
   - Absence of hymenal tissue: wide areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissues, extending to the base of the hymen, which is confirmed in the knee-chest position

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Note: if only anogenital examination findings are available, use this phrase: *"Anogenital findings show clear evidence of blunt force or penetrating trauma."*

2. Finding sperm or seminal fluid in or on a child's body
3. Pregnancy
4. Positive, confirmed cultures for *N. gonorrhea* from vaginal, urethral, anal, or pharyngeal source
5. Evidence of syphilis acquired after delivery (i.e., not perinatally acquired)
6. Cases where photographs or videotape show a child being abused
7. HIV infection, with no possibility of perinatal transmission or transmission via blood products or contaminated needles

Impression: " Medical evaluation suggestive of abuse or sexual contact."

If medical findings or combination of available information are any of the following listed below,
use the above phrase in the Impressions.

1. **Anogenital findings listed below:**

    - Marked, immediate dilation of the anus, with no stool visible or palpable in the rectal vault, when the child is examined in the knee-chest position, provided there is no history of encopresis, chronic constipation, neurological deficits, or sedation
    - Hymenal notch/cleft in the posterior (inferior) portion of the hymenal rim, extending nearly to the vaginal floor (often an artifact of examination technique, but if persistent in all examination positions, may be due to previous blunt force or penetrating trauma)
    - Acute abrasions, lacerations or bruising of labia, peri-hymenal tissues, or perineum (may be from accidental trauma, or may be due to dermatological conditions such as lichen sclerosus or hemangiomas)
    - Bite marks or suction marks on the genitalia or inner thighs
    - Scar or fresh laceration of the posterior fourchette, not involving the hymen (may be caused by accidental injury)
    - Perianal scar (rare, may be due to other medical conditions such as Crohn's Disease, or from previous medical procedures)

2. Child has given a spontaneous, clear, consistent, and detailed description of being molested, with or without abnormal or positive physical findings on examination
3. Positive culture (not rapid antigen test) for *Chlamydia trachomatis* from genital area in prepubertal child, or cervix in an adolescent female (assuming that perinatal transmission has been ruled out)
4. Positive culture for Herpes Simplex Type 2, from genital or anal lesions
5. Trichomonas infection, diagnosed by wet mount or culture from vaginal swab, if perinatal transmission has been ruled out

Note: if only anogenital examination findings are available, use this phrase: *"Anogenital findings are suggestive of blunt force or penetrating trauma."*

Impression: "Medical evaluation does not exclude sexual abuse."

If medical findings or combination of available information are any of the following listed below, use the above phrase in the Impressions.

1. **Normal or non-specific findings (see Appendix B) in combination with significant behavior changes, especially sexualized behaviors, but child unable to give a history of abuse**
2. Herpes Type I anogenital lesions, in the absence of a history of abuse and with an otherwise normal examination
3. *Condyloma accuminata*, with otherwise normal examination; no other STDs present, and child gives no history of abuse (Condyloma in a child older than 3-5 years is more likely to be from sexual transmission, and a thorough investigation must be done)
4. **Child has made a statement but statement is not sufficiently detailed, given the child's developmental level; is not consistent; or was obtained by the use of leading questions concerning physical findings with no disclosure of abuse**

One cannot automatically conclude that no abuse has happened if anogenital findings belong in the normal or non-specific category, especially if physical findings are the only information available to the examiner at that time. Possible explanations for normal or non-specific findings include:

- No abuse happened
- Abuse happened but did not cause injury (e.g., fondling above clothes, oral sex)
- Abuse happened and caused injuries but those injuries have since healed completely

In cases where the examining physician does not have access to additional information, continue to stress the importance of the child's disclosure by including the following caveat after the summary of findings:

"Please correlate medical examination findings with the patient's disclosure."

Certain types of molestation do not result in visible injuries. Examples include: fondling, oral sex, intracrural intercourse. In cases where the child gives a spontaneous, clear, consistent, and detailed description of such abuse, use this phrase:

"The anogenital findings seen in this patient are to be expected in a child who describes this type of molestation."

IT'S NORMAL TO BE NORMAL

Normal or non-specific findings in a patient do not necessarily imply that no abuse occurred. In 1994, Adams, *et al*., conducted a study to determine the frequency of abnormal findings in a population of children with legal confirmation of sexual abuse. In their review of 213 cases with perpetrator conviction for sexual abuse, 77 percent of these girls had normal or non-specific genital examination findings. As Adams notes:

> *"Abnormal findings are not common in sexually abused girls…More emphasis should be placed on documenting the child's description of the molestation, and educating prosecutors that, for children alleging abuse, 'It's normal to be normal.'"*

Further, the Supreme Court of the Philippines ruled in an en banc decision (*People v. Llanita* G.R. No. 134101, September 5, 2001) that "the absence of hymenal lacerations does not disprove sexual abuse."

It is quite common for a medical certificate to be issued immediately after the patient is examined, since a provisional medical certificate is often required for inquest purposes even before the results of the diagnostic and forensic tests are available. As it is also a recommended practice to submit the colposcopic pictures for peer review, the following statement may be used in the medical certificate after the examining physician records the impression:

"The final interpretation of the evaluation and physical findings will be released after the diagnostic and forensic tests are completed and the peer review is concluded."

APPENDICES

- **Appendix A: Abuse Documentation Using Photography and Colposcopy**
- **Appendix B: Joyce Adams' "Evolution of a Classification Scale: Medical Evaluation of Suspected Child Abuse." (February 2001)**
- **Appendix C: Selected Terms from American Professional Society on the Abuse of Children's "Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Examinations."**
- **Appendix D: References**
- **Appendix E: Medico-Legal Certificate**

APPENDIX A: ABUSE DOCUMENTATION USING PHOTOGRAPHY AND COLPOSCOPY

Documentation of visual findings is an important component of child abuse evaluation. Apart from careful examination and written documentation, photographs are useful adjuncts to preserve visual findings. These photographs assist physicians in recalling or re-confirming findings, or in discovering previously undetected results; should a second opinion be required, high quality photographs can be reviewed in lieu of re-examination, thus sparing the child unnecessary trauma. Further, physicians may use photographs to illustrate and further clarify their testimony when serving as expert witnesses in court. Finally, photographs facilitate technical peer review: by obtaining the opinions of their peers on difficult-to-evaluate cases, child protection specialists improve their skills, benefiting from the experience and expertise of others.

A colposcope is a binocular instrument used to visualize ano-genital structures during sexual abuse evaluations. Each colposcope offers a light source and varying magnification capability, and may also attach to a camera in order to photograph genital injuries. Although colposcopic photography is used primarily to document abnormal findings, it may also be prudent to photograph cases with normal findings, as these photographs may be of comparative value if the patient is later re-examined.

Colposcope

APPENDIX B: ADAMS CLASSIFICATION SYSTEM FOR ASSESSING PHYSICAL, LABORATORY, AND HISTORICAL INFORMATION

in Suspected Child Sexual Abuse

The system to be used for classifying hymenal injury is based upon that found in Joyce Adams' February 2001 *Child Maltreatment* publication, entitled "Evolution of a Classification Scale: Medical Evaluation of Suspected Child Abuse," in which medical observations are categorized according to likelihood of abuse. This is a suggested system for classifying medical observations and will likely be revised in the future as we gain more information from research concerning non-abused and abused children and adolescents.

Part I: Anogenital Findings on Examination

NORMAL

Findings that are observed in newborns.

1. Peri-urethral (or vestibular bands)
2. Longitudinal intravaginal ridges or columns
3. Hymenal tags
4. Hymenal bump or mound
5. Linea vestibularis
6. Hymenal cleft/notch in the anterior (superior) half of the hymenal rim, on or above the 3 o'clock- 9 o'clock line, patient supine
7. External hymenal ridge

NORMAL VARIANTS

1. Septate hymen (normal variant)
2. Failure of midline fusion (normal variant)
3. Groove in the fossa in a pubertal female (normal variant)
4. Diastasis ani (normal variant)
5. Perianal skin tag (normal variant)
6. Increased peri-anal skin pigmentation (normal variant)

OTHER CONDITIONS

1. Hemangiomas of the labia, hymen, or perihymenal area (may give the appearance of bruising or submucosal hemorrhage)
2. Lichen sclerosus et atrophicus (may result in friability and bleeding)
3. Bechet's Disease (causes genital and oral ulcers, may be mistakem for Herpes Simplex lesions)
4. Streptococcal cellulitis of perianal tissues (causes red, inflamed tissues)
5. Molluscum contagiosum (warty lesions)
6. Verruca vulgaris (common warts)
7. Vaginitis caused by streptococcus or enteric organisms
8. Urethral prolapse (causes bleeding, appearance of trauma)
9. Vaginal foreign bodies (may cause bleeding, discharge)

NON-SPECIFIC FINDINGS

Findings that may be the result of sexual abuse, depending on the timing of the examination with respect to the abuse, but which may also be due to other causes, or may be variants of normal.

1. Erythema (redness) of the vestibule or peri-anal tissues (may be due to irritants, infection or trauma)
2. Increased vascularity (dilation of existing blood vessels) of vestibule (may be due to local irritants)
3. Labial adhesions (may be due to irritation or rubbing)
4. Vaginal discharge (many causes)
5. Friability of the posterior fourchette or commisure (may be due to irritation, infection, or may be caused by examiner's traction on the labia majora)
6. "Thickened hymen" (may be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma)
7. Apparent genital warts (may be skin tags or warts not of the genital type, may be *Condyloma accuminata* which was acquired from perinatal transmission or other non-sexual transmission)
8. Anal fissures (usually due to constipation or peri-anal irritation)
9. Flattened anal folds (may be due to relaxation of the external sphincter)
10. Anal dilation with stool present (a normal reflex)
11. Venous congestion, or venous pooling (usually due to positioning of child, also seen in constipation)
12. Vaginal bleeding (may be from other sources, such as urethra, or may be due to vaginal infections, vaginal foreign body, or accidental trauma)

SUGGESTIVE OF ABUSE

Findings that have been noted in children with documented abuse, and may be suggestive of abuse, but for which insufficient data exists to indicate that abuse is the only cause. History is crucial in determining overall significance.

1. Marked, immediate dilation of the anus, with no stool visible or palpable in the rectal vault, when the child is examined in the knee-chest position, provided there is no history of encopresis, chronic constipation, neurological deficits, or sedation
2. Hymenal notch/cleft in the posterior (inferior) portion of the hymenal rim, extending nearly to the vaginal floor. (Often an artifact of examination technique, but if persistent in all examination positions, may be due to previous blunt force or penetrating trauma).
3. Acute abrasions, lacerations or bruising of labia, peri-hymenal tissues, or perineum (may be from accidental trauma, or may be due to dermatological conditions such as lichen sclerosus or hemangiomas)
4. Bite marks or suction marks on the genitalia or inner thighs
5. Scar or fresh laceration of the posterior fourchette, not involving the hymen (may be caused by accidental injury)
6. Perianal scar (rare, may be due to other medical conditions such as Crohn's Disease, or from previous medical procedures)

CLEAR EVIDENCE OF BLUNT FORCE OR PENETRATING TRAUMA

Findings that can have no explanation other than trauma to the hymen or perianal tissues.

1. Laceration of the hymen, acute.
2. Ecchymosis (bruising) on the hymen.
3. Perianal lacerations extending deep to the external anal sphincter.
4. Hymenal transection (healed). An area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall.
5. Absence of hymenal tissue. Wide areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissues, extending to the base of the hymen, which is confirmed in the knee-chest position.

Part II: Overall Assessment of Likelihood of Abuse

NO INDICATION OF ABUSE

1. Normal exam, no history, no behavioral changes, no witnessed abuse
2. Nonspecific findings with another known or likely explanation and no history of abuse or behavior changes
3. Child considered at risk for sexual abuse but gives no history and has only nonspecific behavior changes
4. Physical findings of injury consistent with history of accidental injury that is clear and believable

POSSIBLE ABUSE

1. Normal, normal variant or nonspecific findings in combination with significant behavior changes, especially sexualized behaviors, but child unable to give a history of abuse
2. Herpes Type I anogenital lesions, in the absence of a history of abuse and with an otherwise normal examination
3. *Condyloma accuminata*, with otherwise normal examination; no other STDs present, and child gives no history of abuse (Condyloma in a child older than 3-5 years is more likely to be from sexual transmission, and a thorough investigation must be done)
4. Child has made a statement but statement is not sufficiently detailed, given the child's developmental level; is not consistent; or was obtained by the use of leading questions concerning physical findings with no disclosure of abuse

PROBABLE ABUSE

1. Child has given a spontaneous, clear, consistent, and detailed description of being molested, with or without abnormal or positive physical findings on examination
2. Positive culture (not rapid antigen test) for Chlamydia trachomatis from genital area in prepubertal child, or cervix in an adolescent female (assuming that perinatal transmission has been ruled out)
3. Positive culture for Herpes Simplex Type 2, from genital or anal lesions
4. Trichomonas infection, diagnosed by wet mount or culture from vaginal swab, if perinatal transmission has been ruled out

DEFINITE EVIDENCE OF ABUSE OR SEXUAL CONTACT

1. **Clear physical evidence of blunt force or penetrating trauma with no history of accident**
2. Finding sperm or seminal fluid in or on a child's body
3. Pregnancy
4. Positive, confirmed cultures for N. gonorrhea from vaginal, urethral, anal, or pharyngeal source
5. Evidence of syphilis acquired after delivery (i.e., not perinatally acquired)
6. Cases where photographs or videotape show a child being abused
7. HIV infection, with no possibility of perinatal transmission or transmission via blood products or contaminated needles

APPENDIX C: SELECTED TERMS FROM THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN'S "GLOSSARY OF TERMS AND THE INTERPRETATION OF FINDINGS FOR CHILD SEXUAL ABUSE EVIDENTIARY EXAMINATIONS"

Abrasion: *Area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process. An injury.

Anal Fissure: *A superficial break (split) in the perianal skin which radiates out from the anal orifice. A variety of causes including the passage of hard stools, diseases such as Crohn's Disease, and trauma.

Anal Verge: *The tissue overlying the subcutaneous external anal sphincter at the most distal portion of the anal canal (anoderm) and extends exteriorly to the margin of the anal skin.

Annular Hymen: *Hymenal membrane extends completely around the circumference of the vaginal orifice.

Anus: *The anal orifice, which is the lower opening of the digestive tract, lying in the fold between the buttocks.

Attenuation: *Narrowing of the hymen. The term should be restricted to indicate a documented change in the width of the posterior portion of the hymen following an injury.

Clock Position Reference: *Method by which the location of a structure may be designated by the numerals on the face of a clock. The 12 o'clock position is always superior (up). The 6 o'clock position is always inferior (down). The position of the patient must be indicated when using this designation.

Crescentic Hymen: *Hymen with anterior attachments at approximately the 11 o'clock and 1 o'clock positions with no hymenal tissue visible between the two attachments.

Cribriform Hymen: *Hymen with multiple openings.

Ecchymosis: *Hemorrhagic area on the skin due to extravasation of blood into the skin or a mucous membrane. A bruise.

Edema: *The presence of abnormal amounts of fluid in the intercellular space. Swelling.

Erythema: *Redness on the skin or mucous membranes produced by congestion (dilation) of the capillaries. Non-specific finding as it may result from a variety of irritants as well as direct trauma.

Estrogenized Hymen: *Effect of the female sex hormone, estrogen, on the hymen, making it more elastic and distensible. Hymen takes on a thickened, redundant and pale appearance as the result of estrogenization.

Fimbriated Hymen: *Hymen with multiple projections or indentations along the edge, creating a ruffled appearance.

Friability: *Term used to describe tissues that bleed easily. Example: The friability of labial adhesions, that when gently separated may bleed.

*Friability of the posterior fourchette – a superficial breakdown of the skin in the posterior fourchette (commissure) when gentle traction is applied, causing slight bleeding.

Genitalia (external): *The external sexual organs. In males, includes the penis and scrotum. In females, includes the contents of the vulva. (see vulva)

Hematoma: *Mass of usual clotted blood that forms in a tissue, organ or body space as a result of a broken blood vessel.

Hymen: *A membrane which partially or, rarely, completely covers the external vaginal orifice. Located at the junction of the vestibular floor and the vaginal canal. Wide anatomic variation in types: annular, crescentic, fimbriated (denticular), septate, cribriform, imperforate. Wide variation in character of membrane: redundant/thick vs. smooth/thin (velamentous), depending upon age and stage of secondary sexual development.

Hymenal Orifice: *The opening in the hymenal membrane which constitutes the entrance or outlet of the vagina.

Imperforate Hymen: *Hymenal membrane with no opening.

"Intact Hymen": *A term which implies a non-injured hymenal membrane. *The use of this term is to be discouraged due to its non-specificity.*

Laceration: *Injury or tear of tissue.

Mound (bump): *Solid, localized, rounded and thickened area of tissue on the edge of the hymen.

Notch (hymenal notch): *Angular or "V"-shaped indentation on the edge of the hymenal membrane and may extend to the muscular attachment of the hymen. A relatively sharp notch or cleft that persists during multiple examination techniques may be evidence of hymenal trauma.

Perianal Skin Folds: *Wrinkles or folds of perianal skin radiating from the anus, which are created by the contraction of the external anal sphincter.

Redundant Hymen: *Abundant hymenal tissue which tends to fold back upon itself or protrude. A common finding in females whose hymenal membranes are under the influence of estrogen (both infants and adolescents).

Rolled Edges (of the hymen): *The edge (border) of the hymen which tends to roll inward or outward upon itself. May unfold through the use of knee-chest position, application of water, through manipulation with a moistened Q-tip or other techniques.

Septal Remnant: (on the hymen) *Small appendage attached to the edge of the hymen. Commonly located in the midline on the posterior rim.

Septated Hymen: *Hymen with band(s) of tissue that bisects the orifice creating two or more openings.

Transection: (of the hymen) *Tear or laceration through the entire width of the hymenal membrane. In complete transection, the tear extends to (or through) its attachment to the vaginal wall. In a partial transection, the tear does not extend to its attachment to the vaginal wall.

Vagina: *The uterovaginal (genital) canal in the female. This internal structure extends from the uterine cervix to the inner aspect of the hymen.

Vaginal Introitus: *The pubovaginalis muscle which forms the entrance to the vagina. Frequently used synonymously with hymenal orifice.

Vestibule (vaginal): *An anatomical cavity containing the openings of the vagina, the urethra, and the ducts of Bartholin's glands. Bordered by the clitoris anteriorly, the labia on the sides and the posterior commissure (fourchette) posteriorly (inferiorly). The vestibule encompasses the fossa navicularis immediately posterior (inferior) to the vaginal introitus.

Virgin or Virgin State *The use of this term is to be discouraged due to its non-specificity.

Vulva: *The external genitalia or pudendum of the female. Includes the mons pubis, clitoris, labia majora, labia minora, vaginal vestibule, urethral orifice, vaginal orifice, hymen, and posterior fourchette (or commissure).

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MEDICO-LEGAL CERTIFICATE

DEMOGRAPHIC DATA							
PATIENT'S NAME		AGE		DOB		SEX	
PATIENT'S ADDRESS							
CIVIL STATUS		OCCUPATION		NATIONALITY			
REQUESTING PARTY		PLACE, TIME AND DATE OF EXAM					
❑ Acute Evidentiary Examination (within 72 Hours of incident)			❑ Non-Acute Examination				

FINDINGS			
General Physical Findings			
HEIGHT		WEIGHT	
GENERAL SURVEY			
MENTAL STATUS			
PERTINENT PHYSICAL FINDINGS/ PHYSICAL INJURIES			
ANO-GENITAL EXAMINATION			
EXTERNAL GENITALIA			
URETHRA AND PERIURETHRAL AREA			
PERIHYMENAL AREA AND FOSSA NAVICULARIS			
HYMEN			
PERINEUM			
DISCHARGE			
INTERNAL AND SPECULUM EXAMS			
ANAL EXAMINATION			
DIAGNOSTICS AND EVIDENCE GATHERING			
FORENSIC EVIDENCE AND LABORATORY RESULTS			
IMPRESSIONS			

present on the skin below the ligature furrow on the left lateral aspect of the neck. Located on the right side of the chin is a three-sixteenths by one-eighth of an inch area of superficial abrasion. On the posterior aspect of the right shoulder is a poorly demarcated, very superficial focus of abrasion/contusion which is pale purple in color and measures up to three-quarters by one-half inch in maximum dimension. Several linear aggregates of petechial hemorrhages are present in the anterior left shoulder just above deltopectoral groove. These measure up to one inch in length by one-sixteenth to one-eighth of an inch in width. On the left lateral aspect of the lower back, approximately sixteen and one-quarter inches and seventeen and one-half inches below the level of the top of the head are two dried rust colored to slightly purple abrasions. The more superior of the two measures one-eighth by one-sixteenth of an inch and the more inferior measures three-sixteenths by one-eighth of an inch. There is no surrounding contusion identified. On the posterior aspect of the left lower leg, almost in the midline, approximately 4 inches above the level of the heel are two small scratch-like abrasions which are dried and rust colored. They measure one-sixteenth by less than one-sixteenth of an inch and one-eighth by less than one-sixteenth of an inch respectively.

On the anterior aspect of the perineum, along the edges of closure of the labia majora, is a small amount of dried blood. A similar small amount of dried and semifluid blood is present on the skin of the fourchette and in the vestibule. Inside the vestibule of the vagina and along the distal vaginal wall is reddish hyperemia. This hyperemia is circumferential and perhaps more noticeable on the right side and posteriorly. The hyperemia also appears to extend just inside the vaginal orifice. A 1 cm red-purple area of abrasion is located on the right posterolateral area of the 1 x 1 cm hymenal orifice. The hymen itself is represented by a rim of mucosal tissue extending clockwise between the 2 and 10:00 positions. The area of abrasion is present at approximately the 7:00 position and appears to involve the hymen and distal right lateral vaginal wall and possibly the area anterior to the hymen. On the right labia majora is a very faint area of violet discoloration measuring approximately one inch by three-eighths of an inch. Incision into the underlying subcutaneous tissue discloses no hemorrhage. A minimal amount of semiliquid thin watery red fluid is present in the vaginal vault. No recent or remote anal or other perineal trauma is identified.

REMAINDER OF EXTERNAL EXAMINATION: The unembalmed, well developed and well nourished caucasian female body measures 47 inches in length and weighs an estimated 45 pounds. The scalp is covered by long blonde hair which is fixed in two ponytails, one on top of the head secured by a cloth hair tie and blue elastic band, and one in the lower back of the head secured by a blue elastic band. No scalp trauma is identified. The external auditory canals are patent and free of blood. The eyes are green and the pupils

How Did Gender and Class Shape the Age of Consent Campaign Within the Social Purity Movement, 1886-1914?

Abstract

"Age of consent" referred in the late nineteenth century to the legal age at which a girl could consent to sexual relations. Men who engaged in sexual relations with girls before they reached the legal age of consent could be found guilty of statuatory rape. American reformers were shocked to discover that the laws of most states set the age of consent at ten or twelve. Women reformers and social purists initiated a campaign in 1885 to petition legislators to raise the legal age of consent to at least sixteen in all states in the nation, although their ultimate goal was to raise the age to eighteen. The documents brought together in this project show that the age-of-consent campaign inspired a broad base of support because it expressed deep cultural tensions over gender, class, and race.

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How Did Gender and Class Shape the Age of Consent Campaign Within the Social Purity Movement, 1886-1914?

Introduction

From Ernest A. Bell, *Fighting the Traffic in Young Girls, or the War on the White Slave Trade* (Chicago, 1910).

Documents selected and interpreted by
Melissa Doak, Rebecca Park, and Eunice Lee
State University of New York at Binghamton
Fall 2000

"Age of consent" referred in the late nineteenth century to the legal age at which a girl could consent to sexual relations. Men who engaged in sexual relations with girls before they reached the legal age of consent could be found guilty of statutory rape. American reformers were shocked to discover that the laws of most states set the age of consent at the age of ten or twelve, and in one state, Delaware, the age of consent was seven. Women reformers and social purists initiated a campaign in 1885 to petition legislators to raise the legal age of consent to at least sixteen, although their ultimate goal was to raise the age to eighteen.[1]

The campaign ultimately proved very successful; by 1920 almost every state had raised the legal age of consent to either sixteen or eighteen.

The campaign attracted diverse supporters. Its mainstream consisted of white middle-class women who championed many of the issues raised by the American Female Moral Reform Society in the 1830s and 1840s: the elimination of prostitution and the end of predatory male sexual behavior.[2] The campaign also drew support from the suffrage movement, since leaders like Elizabeth Cady Stanton believed that male sexual privilege contributed to women's second-class citizenship. Because the movement focused so strongly on the risks incurred by wage-earning girls while away from home, it also recruited the support of reformers who sought to improve women's working conditions. But the movement did not gain the support of politically-active African-American women, who feared that stricter criminal laws would lead to further targeting of African-American men, while doing little to protect young black women in the South from sexual exploitation by white men.

The campaign rested on a narrative of seduction that portrayed middle- and upper-class men as sexual predators who preyed on the innocence of young, white, working girls. Some of these girls, reformers believed, were lured into "white slavery," a system of prostitution in which women were bought and sold, while other girls were simply left to suffer a fate worse than death: the loss of their virtue. These middle-class women, however, commonly ignored the plight of African-American women, who were subject to gross sexual exploitation and victimization.[3]

The age-of-consent campaign was part of a larger social purity campaign in the late-nineteenth century that aimed to reform the morals of American society. The movement began in the 1870s in response to efforts to regulate prostitution in American cities; social purists organized to defeat efforts to regulate prostitution, believing that prostitution was a social evil that needed to be abolished, not regulated. The key organization in this movement was the New York Committee for the Prevention of the State Regulation of Vice, led by Aaron Macy Powell and his wife, Anna Rice Powell, Emily Blackwell, Abby Hopper Gibbons, and Elizabeth Gay. These reformers generally believed that male sexual exploitation led women into prostitution. They publicized their purity ideals through the organization's journal, the *Philanthropist*, founded in 1885.[4]

Women's groups, most importantly the Woman's Christian Temperance Union, also supported the social purity movement and in particular the age-of-consent campaign. The WCTU created an official Social Purity Department in 1885, at the beginning of the campaign to raise the legal age of consent. The WCTU undertook educational and reform work to protect women from moral downfall, but just as importantly, they aimed to transform attitudes toward the sexual double standard.

The WCTU organized purity societies for boys and men to help them resist sexual temptation. The organization also undertook a major petition drive to convince legislators to raise the age of consent and make sexual contact with adolescent girls illegal. The WCTU publicized all of their social purity activities through their journal, the *Union Signal*.[5]

Woman's rights activists also supported the age of consent campaign because of their view that male privilege resulted in the sexual ruin of young women, and they used the pages of the *Woman's Journal*, the leading national suffrage publication, to inform readers of the progress of the campaign. Some women's rights supporters, notably Emily Blackwell, Elizabeth Cady Stanton, and Helen Hamilton Gardener (see documents 13, 14, 15) came to argue that adequate legal protection of women and girls could only be achieved when women won the right to vote. Stanton highlighted how male sexual privilege contributed to women's second-class citizenship in her preface to Gardener's novel about a young working girl who was seduced and ruined by her employer. She wrote, "I have long waited and watched for some woman to arise to do for her sex what Mrs. Stowe did for the black race in 'Uncle Tom's Cabin,' a book that did more to rouse the national conscience than all the glowing appeals and constitutional arguments that agitated our people during half a century. . . . In Helen Gardener's stories, I see the promise, in the near future, of such a work of fiction, that shall paint the awful facts of woman's position in living colors that all must see and feel." (See Document 13) These women activists felt strongly the injustice of the sexual double standard and argued it must be abolished before women could truly be emancipated.

The age-of-consent campaign inspired a broad base of support because it expressed deep cultural tensions over gender, class, and race. Middle-class women reformers believed that female downfall was a direct result of male exploitation, and yet they did not question the purity of themselves and their daughters; rather, they argued that working-class girls, outside of the protection of a good home, were the targets of male vice. These women did not challenge the sexual exploitation of African-American women either; the slow rate at which Southern women took up the age-of-consent campaign illustrated their reluctance to protect black women from sexual violence.[6] The following documents illustrate these tensions within the campaign to raise the age of consent.


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Document 1: Aaron Powell, "Legal Protection For Young Girls," *Philanthropist*, 1 (January 1886), pp. 2-3.

Introduction

Dr. Aaron Macy Powell, an editor of the *Anti-Slavery Standard*, published from 1840 to 1872, enthusiastically embraced the campaign to abolish prostitution and vice in the 1870s. When the American Committee for the Prevention of Legalizing Prostitution met in Washington, D.C. in 1877, Powell became a national leader of the purity movement. He began publishing a journal in 1879, which in 1886 expanded into the *Philanthropist*, the official American social purity journal published in New York City. Powell attempted to arouse public concern over the low age of consent in the following editorial.

LEGAL PROTECTION FOR YOUNG GIRLS

The true function of government is the protection of the weak against the strong. Among those most in the need of legal safeguards are young girls, especially of the poor and dependent, and therefore greatly exposed class. It is very largely from this class, particularly in large cities, that the supply is furnished for well-to-do debauchees, who demand, and are able to pay for, victims of their lust. The daughters of the wealthy, and those of good and comfortable home environments, are sometimes, though rarely, ensnared. The children of poverty or misfortune are the ones chiefly preyed upon.

The time is at hand for a more careful and searching examination of this subject than it has hitherto received. The moral sense of the civilized world has greatly shocked a few months ago on being made aware that until the recent adoption by Parliament of the Criminal Law Amendment Bill[A], young girls of thirteen in Great Britain were legally capable of giving "consent" to their own debauchery, and that there was no legal redress against their despoilers. By the adoption of that law, the "age of consent" was, under the irresistible pressure of an aroused, indignant public opinion, raised to sixteen years, though the

age of eighteen was recommended by Mr. Gladstone[B], and strongly urged by others. Even under French and other Continental Common Law the minor, under the age of twenty-one, cannot legally consent to her own corruption, and the adult who debauches her cannot plead "consent" in defense, and is subject to punishment. The property of minors here, under the age of twenty-one, is surrounded with legal safeguards. Is the person less sacred?

What is the legal protection extended to young girls in the State of New York? It will doubtless astonish many of our readers, who have hitherto avoided the subject as indelicate, or painful, to be told, that the young girl of the Empire State is held, by its criminal laws, to be legally capable of giving "consent" to her own corruption at the tender age of TEN YEARS! That, if assaulted and overpowered, if it be shown in court that she did not resist to the uttermost limit of exhaustion, the man(?), who assaulted her may still successfully plead "consent." This is, indeed, protection with a vengeance--the protection which the wolf extends to the lamb! Seduction of young girls is made a punishable offense only for breach of promise of marriage. Nor is New York alone, or singular, among the several States in fixing the legal "age of consent" at ten years. In New Jersey, Maryland and many other States of the Union, and in the National Capital, the age of consent is held to be ten years! With such a legal status for young girls, and the comparative impunity with which vicious and designing men may pursue their evil ways, the flagrant exhibitions of vice in our large cities, the abandoned girls in their teens in the streets, detestable in the extreme, are in nowise surprising. It is the young, ignorant, and inexperienced, who are most easily led astray, especially the children of pinching poverty and want.

The New York Committee for the Prevention of State Regulation of Vice have addressed a petition to the New York Legislature asking that body to provide, by appropriate legislation, exemplary penalties for seduction, with or without the promise of marriage, and for the defilement of the persons of young girls, without or with consent, under the age of at least eighteen years. The Committee have addressed a similar petition to Congress asking for kindred legislation for the better protection of young girls in the national capital. It is greatly to be desired that the friends of social purity in other States should at once take similar action, and thus endeavor to remove one of the most prolific causes of the crying social evil which imperils the home, and begets so much suffering and ruin. Mr. Gladstone's maxim that "it is the province of government to make it easy to do right and difficult to

do wrong," is exactly reversed by the unjust laws which render young girls of ten or twelve years the easy prey of bad and viciously inclined men. It is a striking illustration of the wretched work men alone have done in legislating upon a subject wherein the interests and welfare of both sexes are so vitally involved. Women and true, high-minded, honorable men should everywhere join, heartily and resolutely, in a common effort to abolish, promptly and forever, the great wrong, and to surround the persons of young girls, as well as property, with adequate legal safeguards.

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A. The Criminal Law Amendment Act was passed in Britain in response to the public outcry following William T. Stead's exposé of white slavery in "The Maiden Tribute to Modern Babylon," published in the *Pall Mall Gazette* in 1885. The Act raised the age of consent from thirteen to sixteen.

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B. William E. Gladstone (1809-1898) was a four-time prime minister of Great Britain (1868-74, 1880-85, 1886, 1892-94).

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Document 2: Aaron M. Powell, "The Moral Elevation of Girls," *Philanthropist*, 1 (February 1886), pp. 5-6.

Introduction

In the following article, Powell reported on the activities of Grace H. Dodge and Virginia Potter, who had formed a Working Girls' Society in New York City. Dodge, recognizing the importance of preventive work to keep girls "pure," took the unusual step of providing sex education to working women.[7] In this article, Powell especially emphasized the importance of well-to-do "ladies" providing examples to working women to help them resist the temptations that purity reformers believed went hand-in-hand with working in factories and department stores. This emphasis highlighted the class aspects of both purity reform and the age-of-consent campaign--daughters who did not go out to work, reformers believed, remained protected within their families. Working women were preyed upon by seducers--often their employers, supervisors, or customers.

THE MORAL ELEVATION OF GIRLS.

One of the encouraging signs of this era is the tendency in all philanthropic efforts to consider more the causes of evils which we are called upon to alleviate. A good illustration of this praiseworthy, preventive work is the Committee of the State Charities Aid Association of New York, which aims for the elevation of the poor in their homes, of which Miss Grace H. Dodge is chairman and Miss Virginia Potter secretary. From a report recently published, giving suggestions concerning this effort, we quote the following: "Many earnest women are devoting their lives to the task of raising those who have fallen, but many more are needed to hinder others from falling, to thwart the evil that threatens young lives, to interrupt temptation, and stop the feet of those who run to destruction."

The practical methods employed for reaching those who need this helpfulness are the formation of Girl's "Friendly" Societies, Working Girl's Societies, Good Will Clubs, etc. In these organizations, by wise tact and a sympathetic interest, the members are led to conduct them

themselves, the aim being to encourage self-respect and to stimulate a general improvement of character. These young girls are very sensitive to any thing that has the aspect of a charity and these efforts wisely take on the character of co-operative help. The evenings are made pleasant and profitable. Instruction and amusement are blended, opportunities are given for friendly talks on many topics, and confidential relations are established. Some of the women who have become interested in these young girls in this way have had revelations of the temptations which assail them that have led them to see the necessity of broadening the efforts for their protection. We commend to all a careful reading of the thoughts presented in this pamphlet under the heading of Girlhood, from which we make the following extracts:

"In all intercourse, ladies should show loving attention in little things to the girls. They crave love and its demonstration, and seldom receive it from an overworked mother or grasping father. What wonder that they readily believe the first man who promises it to them, and that they are so often led astray by their affection. The temptations put forth in alluring shape by the foremen, superintendents, and other men working in the same shop or factory, can hardly be believed by those who are not subjected to such influences. It is a horrible thought that hundreds of girls are led into lives of sin by those who ought to protect and guard them. Three girls were once found in the maternity ward of a New York hospital all giving the same name as that of the man who had brought them to deep distress and who was the foreman of the factory where they all worked."

"To give the girls some knowledge of their physical structure and the special functions of their sex, to teach them to reverence the body as the very temple of the Holy Spirit, and to deplore every thought, act, and habit that profanes it; to urge them to shun every temptation to impurity, and to guard themselves and others from the first approaches of evil--these are the lessons and counsels which every older woman who befriends these young girls should be prepared to impress upon them. To ignore these subjects is to neglect a most important part of this preventive work, and to neglect that has brought shame and misery into many a young life. But the method of giving this instruction must be left to the individual teacher. It must be in accordance with her character and experience. Great harm can be, and has been done, by the indiscriminate presentation of ideas and images that may shock and offend a young person’s sensibilities. That wise reserve in regard to the relations of the sexes which characterizes the English speaking

race is not to be lightly broken in upon. At the same time there are often cases where the plainest language should be used. Whether in an impersonal way, to several girls in a class, or privately, to one alone, must depend upon circumstances."

"At a time when a girl's head is naturally full of romance, love and marriage, it is most desirable that her older lady friend (or, if it happen so, her young lady friend) should encourage her to talk about the men she is seeing, and the attentions she receives from them. For this may lead to many important confidences, and the girl's life, in consequence, may be guarded from evil and largely influenced for good. Only those who feel the great responsibility of this confidential intercourse should undertake it, however. The influence of a refined girl upon one of coarser nature is wonderful, but there should be no false notes struck here! Like the quality of mercy, this intercourse is twice blessed when reverently conducted: it blesses the giver, who constantly learns more the meaning of her own pure womanhood, and to whom foolish jesting becomes more and more hateful as she recognizes the injury done by it in the lives of young girls. It blesses the taker, who sees the beauty of holiness in the life of her friend, and who aims to make her own life beautiful in the same way. It is holy ground on which to stand. None should approach it presumptuously. Again, let none fear to do so whose hearts are touched with the sentiment of love. The way will be shown and the light will grow clearer and brighter. Only let all look to the common Heavenly Father for guidance and help. Let rich and poor, high and low, gentle and simple, refined and coarse, educated and ignorant, know Him as one who loves and cares for them, not only in the great matters of their lives, but in their daily little trials and perplexities. So, in teaching that no noble life can be led without Him, all will learn that they may enter the kingdom of heaven now, and it shall be to all their present peace and future home."

We need not despair of reaching better conditions of society when this phase of philanthropic work is undertaken in this spirit and with these ennobling ends in view. Supplementing this teaching with that of the White Cross Movement, which appeals to the better instincts of manhood, we shall in time attain to the ideal standard of social purity so much to be desired.

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Document 3: "The International Traffic in Girls," *Philanthropist*, 1 (June 1886), p. 4.

Introduction

Purity reformers believed the "white slave traffic" could be combated by raising the legal age of consent. The following document, a memorial sent to Congress by the New York Committee for the Prevention of State Regulation of Vice, argued that Canadian girls were brought into the United States to be prostitutes, and asked legislators to take action to stop the traffic. Reformers, emphasizing the protection of white women, ignored entirely the serious sexual exploitation suffered by African-American women.

THE INTERNATIONAL TRAFFIC IN GIRLS.

THE NEW YORK COMMITTEE FOR THE PREVENTION OF STATE REGULATION OF VICE, on the 22d ult., adopted the following memorial to Congress in relation to the alleged traffic in young girls for immoral purposes:

MEMORIAL

To the United States Senate and House of Representatives:

Whereas, a Quebec telegram of the 16 ult.,widely published says:--

"Wholesale trading in young and innocent girls for the purpose of prostitution has come to the notice of the authorities.

Agents from disreputable houses in the large cities in the United States have been in the habit of coming here and have ingratiated themselves with young women and got them to go the United States, where they are drawn into a life of infamy.

The trade has been carried on to an alarming extent, sometimes as many as fifteen girls being shipped in a week." The telegram adds: "The police authorities and clergy held a consultation to-day over the

abduction of two young women to Chicago by a female, who intends to dispose of them for immoral purposes. The girls left by the Grand Trunk railway[A] on Monday night, and every attempt was made to arrest the woman within the Canadian line. The American consul has been consulted, and an important letter has been drafted for the British consul in Washington.

It is stated that over fifty girls have been sent to one Chicago house within a year;" therefore your memorialists, the New York Committee for the Prevention of State Regulation of Vice, respect fully and earnestly ask that you will duly provide for, and cause to be made, a thorough official inquiry concerning this alleged international traffic in girls for immoral purposes, and take such action as may be found necessary to speedily and effectually abolish it.

ABBY HOPPER GIBBONS, *President*[B]
AARON M. POWELL, *Vice President*
EMILY BLACKWELL, M.D., *Vice President*[C]
ANNA RICE POWELL, *Secretary*[D]
ELIZABETH GAY,*Treasurer*[E]

New York, May 22, 1886

The memorial has been forwarded to Washington for presentation in both the Senate and House of Representatives.

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A. The Grand Trunk Railway connected Canada and the United States.
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B. Abby Hopper Gibbons was the president of the New York State Committee from 1876 to 1893. Before the age-of-consent campaign, she was involved in activities to reform ex-prostitutes. Gibbons started the Issac T. Hopper Home, which was a halfway home for women who had recently left prison to enable them to readjust to life in the outside world.

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C. Emily Blackwell, sister of Elizabeth Blackwell, the first woman in the United States to receive a degree as doctor of medicine, was a leading moral educationist in the years following the Civil War. For more on Blackwell's involvement in the age-of-consent campaign, see Document 14.

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D. Anna Rice Powell was the wife of Aaron Powell. She was also a Vice President of the American Purity Alliance when it was founded in 1895.

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E. Elizabeth Gay was a major leader in purity reform, serving as the treasurer of the New York Committee and as a Vice President of the American Purity Alliance after its founding in 1895.

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Document 4: "The Age of Consent," *Union Signal*, 10 June 1886, pp. 2-3.

Introduction

The age-of-consent campaign relied upon a narrative of seduction in which an older, middle- or upper-class man seduced a young, working-class girl for its appeal to women activists, who viewed low legal ages of consent as evidence of male privilege and female victimization. According to historian Mary Odem, this narrative was not based on reality. Rather, although working-class girls were beginning to form intimate and sometimes sexual relationships with men, their boyfriends were usually young, unmarried, working-class youth, not older men or their employers.[8] The following article, reprinted from the *Boston Index*, used the seduction narrative to justify the proposed changes in Massachusetts law.

THE AGE OF CONSENT

As we all know, Massachusetts is making a brave fight to have the age of consent raised to at least thirteen years. This movement has met with opposition from unexpected quarters, Mr. T. W. Higginson[A] and other excellent men opposing it, seemingly from the fear that it will work injustice to very young men in that it does not give them protection against designing, dissolute women. Harriette R. Shattuck replies to his structure at length in *The Index.* She makes some excellent points which we give in full, because they will be helpful to women in other states who are fighting the same battle. She says:

As the laws now stand in our Massachusetts statutes, cases of violence (where the victim does not "consent") are punished by imprisonment in the state prison for life or for a term of years. This same penalty is prescribed when the offence is committed against a girl-child *under ten*, when she does "consent." When the girl is over ten, the offence becomes mutual, and is punished, in both parties, by a small fine or by three months imprisonment in jail. In other words, no matter what the age of the man is, the girl, a victim at nine, becomes a criminal at ten; and a sin to which it is very easy to claim that she "consents" (for no matter how ignorant or unsuspecting she may be, till too late to save herself) is punished as a crime. The girl of ten years is

therefore held equally guilty with the man of twenty, forty, or eighty years of age. This last is not exaggeration, the present writer having learned of a case where the girl was twelve and the man eighty, with all the difference of knowledge and design on the one hand and ignorance and innocence on the other that this implies.

What we desire is that, in the law relating to violence, the age at which the girl may "consent" and still be legally held a victim, and not a criminal, shall be raised to at least thirteen. Also, in addition to this, that a new law shall be passed by which girls shall be protected from thirteen to eighteen (not to twenty-one), by making seduction a crime on the part of the man, with a lighter penalty than that for violence, but one which shall be sufficient to discourage the prostitution of children and the traffic, on the part of middle-aged and old men, in girls under eighteen. At present, seduction in itself is not a crime and is not punished. When the two "have sinned conjointly," the act itself becomes a crime, and is punished by equal penalties. But all that which comes before the act, and which makes the vast difference between the aggressor and the victim, is not taken into account in the law. The fact we want recognized is that, in the majority of cases of seduction, the girl is not a criminal, but a victim, and needs not punishment, but protection. The design of the petitioners is not to excuse girls of profligate habits, nor to protect them in their evil ways, but to protect children and young girls of pure lives from the many men whose chief pleasure it seems to be to go about, and with devilish insinuations, promises of marriage, and words of so-called "love," to persuade good girls to do wrong.

This brings me to the third point necessary to be taken into account; and that is the vast difference in the case of the man on the one hand, and the case of the girl on the other. In the first place, it is well known that almost all girls are brought up in ignorance of the wiles of men, while almost all boys are fully equipped with the knowledge, and in the majority of cases, commit the sin with their eyes wide open. It is also well known that, while the social penalty for boys and men is almost nothing, that for girls and women it is damning. Also, that the sorrow from and the effects of the sin fall almost entirely upon the woman, while except in the sight of God, and under the righteousness of his equal penalties, the man goes scot free.

Mr. Higginson urges that the boys also need protection; and to this no one can object, although a careful reading of the laws concerning houses of ill-fame and night-walking will show that men

have quite well protected themselves in these matters. It may also be pointed out that the state, by its statutes, deals very gently with juvenile offenders. Still, if the legislature should think it necessary to enact a law protecting boys under eighteen from seduction, the advocates of this movement would doubtless give it their endorsement. But at present this does not seem of such immediate importance. When old women of eighty, and married and unmarried women of middle age, in *good society and of fine social standing*, go about ruining boys of ten and twelve and sixteen it will be time to sound the alarm for boys as we are sounding it for girls.

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A. For a sketch of Higginson, see the biographical sketches included in the editorial project on male supporters of women's rights, also on this website. For an essay by Higginson, see document 11 of that project, "Ought Women to Learn the Alphabet?"

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Document 5: "Protection of Girlhood," *Philanthropist*, 1 (October 1886), p. 2.

Introduction

The following article outlined strategies recommended for use in various states to influence legislators to raise the age of consent. The author also argued, in accordance with the narrative of seduction outlined in Document 4, that working-class girls were particularly in need of protection.

PROTECTION OF GIRLHOOD.

We published elsewhere a petition asking better legal protection for women against assault, and that the "age of consent" on the part of young girls be raised to at least eighteen years, recently issued by the National Woman's Christian Temperance Union for general circulation, which we commend to the attention and hearty co-operation of our readers in all parts of the country. It may be most usefully employed in petitioning any and all State legislatures, and duplicates may be also as appropriately addressed, simultaneously, to the Congress of the United States from the citizens of every State in the Union.[A]

In most of the States, as we have heretofore mentioned, the "age of consent," in cases of assault, is ten years, in a few twelve, in Iowa and Massachusetts it was by their last legislatures raised to thirteen, and in Washington Territory (where women are voters) to sixteen. In the District of Columbia, the national capital, under the exclusive jurisdiction of Congress, it is ten years. In one State, Delaware, it is at the shockingly low period of SEVEN years! This is a state of things thoroughly discreditable to the law makers of the States and of the nation. We invited attention to it, and strongly urged prompt remedial action in the first number of THE PHILANTHROPIST, at the beginning of the present year, while Congress and many of the State legislatures were yet in session. In Iowa and Massachusetts, as we have stated, the subject was under consideration and the age changed to thirteen years. In the Legislatures of New York, New Jersey, and other States, petitions issued by the New York Committee for the Prevention of State Regulation of Vice were presented, but no action taken. In

Maryland a bill raising the "age of consent" was passed by the Senate and defeated by the House. Petitions were presented, and bills introduced, in both branches of Congress raising the age to eighteen, and they are still pending before the committees having them in charge.

A new legislative season is now at hand. In a few weeks Congress will again be in session, and also many legislatures in different States. It is opportune, therefore, to inaugurate now the work of securing for early use many numerously signed petitions. With less labor, influential petitions may be made available, officially signed by the president and other officers of Social Purity Alliances, White Cross Leagues, Woman's Christian Temperance Unions, and other philanthropic organizations, and from churches and other religious bodies, officially signed by pastors and officers. All may not yet vote, but all irrespective of sex, may use at once the petition. Candidates for the legislatures, many of whom are about to be re-elected, may with great fitness and usefulness be interrogated by constituents concerning their willingness if elected, to extend more adequate legal protection to women and young girls, and all such as hesitate or oppose should by all means be elected to stay at home. The same interrogation should also be extended to candidates for Congress. It is quite time that the social purity test be applied impartially to all candidates for legislative public service, State and national.

For the daughters of the wealthy and favored classes, shielded from exposure and protected by good home environments, there is relatively little need for legislative interposition. For the poor and dependent, for the multitudes of young and greatly exposed working girls in our large cities, the situation is very different and the need of added legal safeguards is most urgent. The purse of the young girl, if she had one, is guarded by the State and the nation until she shall have reached mature womanhood. Much more important is it to her and to society at large, that her person be as fully protected, by equally effective legal safeguards, from the wiles or the violence of the sensual despoiler.


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A. For a copy of the WCTU petition, see Document 9.

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Document 6: Josephine E. Butler, "The Double Standard of Morality," *Philanthropist*, 1 (October 1886), pp. 1-2.

Introduction

Josephine Butler led the fight to repeal the series of contagious diseases acts passed in Britain between 1864 and 1869 that effectively regulated, rather than abolished, prostitution. In 1875, Butler led in forming the British, Continental, and General Federation for the Abolition of State Regulated Prostitution. Her work was greatly admired in the American social purity movement. In the following article, Butler argued against the double standard, which held women responsible for sexual indiscretions while excusing the behavior of men. A major goal of the age-of-consent campaign was to eliminate this double standard.

THE DOUBLE STANDARD OF MORALITY

BY JOSEPHINE E. BUTLER

As a floating straw indicates the flow of the tide, so there are certain expressions that have become almost proverbial and till lately have passed unchallenged in conversation and in literature, plainly revealing the double standard of morality which society has accepted. One of these expressions is, "He is only sowing his wild oats;" another is, that "a reformed profligate makes a good husband." The latter is a sentiment so gross that I would not repeat it, if it were not necessary to do so--as a proof of the extent of the aberration of human judgment in this matter.

Here we are at once brought into contact with the false and misleading idea that the essence of right and wrong is in some way dependent on sex. We never hear it carelessly or complacently asserted of a young wom[a]n that "*she* is only sowing her wild oats." This is not a pleasant aspect of the question; but let us deal faithfully with it. It is a fact, that numbers even of moral and religious people have permitted themselves to accept and condone in man what is fiercely condemned in woman.

And do you see the logical necessity involved in this? It is that a large section of female society has to be told off--set aside, so to speak, to minister to the irregularities of the excusable man. That section is doomed to death, hurled to despair; while another section of womanhood is kept strictly and almost forcibly guarded in domestic purity. Thus even good and moral men have so judged in regard to the vice of sexual immorality as to concede in social opinion *all* that the male profligate can desire. This perverse social and public opinion is no small incentive to immorality. It encourages the pernicious belief that men may be profligate when young without serious detriment to their character in after-life. This is not a belief that is borne out by facts.

Marriage does not transform a man's nature, nor uproot habits that have grown with his years: the licentious imagination continues its secret blight, though the outward conduct may be restrained. The man continues to be what he was, selfish and unrestrained, though he may be outwardly moral in deference to the opinion of that "society" which having previously excused his vices, now expects him to be moral. And what of that other being, his partner--his wife--into whose presence he brings the secret consciousness, it may be the hideous morbid fruits, of his former impurity? Can any man, with any pretension to true manliness, contemplate calmly the shame--the cruelty--of the fact that such marriages are not exceptional, especially in the upper classes?

The CONSEQUENCES of sins of impurity far out-last the sin itself, both in individuals and in communities. Worldly and impure men have thought, and still think, they can separate women, as I have said, into two classes,--the protected and refined ladies who are not only to *be good*, but who are, if possible, to *know* nothing except what is good; and those poor outcast daughters of the people whom they purchase with money, and with whom they think they may consort in evil whenever it pleases them to do so, before returning to their own separated and protected homes.

The double standard of morality owes its continued existence very greatly to the want of a common sentiment concerning morality on the part of men and women, especially in the more refined classes of society. Men are driven away at an early age from the society of women and thrown upon the society of each other only--in schools, colleges, barracks, etc.; and thus they have concocted and cherished a wholly different standard of moral purity from that generally existing

among women. Even those men who are personally pure and blameless become persuaded by the force of familiarity with male profligacy around them, that this sin in *man* is venial and excusable. They interpret the ignorance and silence of women as indulgent acquiescence and support.

Women are guilty also in this matter, for they unfortunately have imitated the tone and sentiments of men, instead of chastening and condemning them; and have shown, too often, very little indeed of the horror which they profess to feel for sins of impurity. Now we have the profound conviction that not only must as many men and women as possible severally understand the truth concerning their relations to each other, but also that they must learn the lesson in each other's presence, and with each other's help. A deeply-reaching mutual sympathy and common knowledge must (if we are ever to have any real reform) take the place of the life-long separation and antipathetic sentiments which have prevailed in the past.

Obviously, then, the essence of the great work which we propose to ourselves, is to Christianize public opinion, until both in theory and practice, it shall recognize the fundamental truth that the essence of right and wrong is in no way dependent upon sex, and shall demand of men precisely the same chastity as it demands of women.

It is a tremendous work which we have on hand. Licentiousness is blasting the souls and bodies of thousands of men and women, chiefly through the guilt of the men of the upper and educated classes. The homes of the poor are blighted--the women among the poor are crushed--by this licentiousness, which ever goes hand in hand with the most galling tyranny of the strong over the weak. The press and the pulpit, apparently dismayed by the enormity of the evil, the one sometimes in sympathy with it, the other losing faith in the power of God and in spiritual revival, have ceased altogether to administer any adequate rebuke. In our homes and in social circles mistaken delicacy has come to the aid of cowardice, and the truth is betrayed even in the house of its friends. The warnings of God are concealed, and young men and women are left to be taught by sad and irremediable experience the moral truths which should be impressed upon them early in life by faithful instructors.

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Document 7: Frances E. Willard, "Social Purity Work for 1887," *Union Signal*, 13 January 1887, p. 12.

Introduction

Frances Willard, president of the WCTU, outlined several facets of the organization's social purity work in this article published the *Union Signal*. The WCTU sponsored several organizations to teach purity values to young people, including the White Cross Society and the Silver Crown, two groups for men and boys who pledged to keep themselves morally pure, and the White Shield and Daughters of the Temple, the female counterparts to the male societies. The WCTU also organized mothers' meetings aimed at providing instruction to mothers on how to raise children to be good citizens in harmony with social purist ideas. At the end of the article, Willard reprinted the petition that members of the WCTU were circulating to raise the age of consent in various states (see Document 9). All of these activities were aimed at eliminating the sexual double standard for men and women. The age-of-consent campaign explicitly placed the blame for sexual improprieties on the male seducers of adolescent girls. For more on Willard and the WCTU, see "Why Did African-American Women Join the Woman's Christian Temperance Union between 1880 and 1900?" an editorial project on this website.

SOCIAL PURITY WORK FOR 1887

———

FRANCES E. WILLARD

———

National Headquarters W.C.T.U.,
161 LaSalle Street, Dec 15. 1886. Chicago, Ill.

One year has taught us much. "What not to do, is often a query more difficult than "What to do?" Last year our eyes were always looking over our shoulders to see the way they worked in England. This was natural enough, because the Mother Country was several years earlier in the field, had pioneered the path, and had developed something in the line of methods. Last year we studied the wonderful uprising that resulted in the Criminal Reform Bill[A]--a measure which Parliament had toyed with for nine sessions, and only adopted at the

point of that sharpest of bayonets--aroused and concentrated public opinion. Last year we rejoiced over the expurgation from Great Britain's legislative records of those barbarous Contagious Diseases Acts[B], the repeal of which was said by the London *Times* to be the greatest personal triumph ever won by a woman--and that woman Mrs. Josephine Butler, the first of her sex who ever publicly raised up a standard against the legalized degradation of the world's gentler half. Last year we studied the wonderful White Cross movement, under the wise and thoughtful guidance of Miss Ellice Hopkins[C] of Brighton, England, and the Rev. Dr. B. F. De Costa[D] of New York, through whose efforts the society has now been endorsed by the Episcopal Church at its Triemnial Session, in Chicago, and broadened by the seven methods of the clergy's official "Declaration" until it is better adapted to the spirit of our people. All this was noble tutelage, and though possibly we might have done better than the record shows in some particulars, we nevertheless made a beginning, and "it is the earliest step that costs."

Nearly every state in the Union appointed a superintendent of work for the promotion of social purity, and thousands of local unions began the study of arguments and methods. Sixty thousand of Miss Hopkins' White Cross Leaflets were ordered from our National Headquarters 161 LaSalle Street, Chicago, and thirty-three thousand White Cross pledges. Letters by thousands were received and answered, and documents relative to the work sent out, not only through the United States, but the civilized world; for this great awakening seems like a wave of spiritual power belting the earth.

But 1887 is here, and what are now our plans? They involve some points that are now. As before, we have grouped the work under three heads: Preventive, Reformatory and Legislative.

Under the first our effort will be chiefly to carry forwards the plans of the White Cross Societies. These are given at length in the "White Cross Manual," which we have just brought out, and which is for sale at our Headquarters, 161 LaSalle Street, Chicago.

THE WHITE CROSS SOCIETY

is formed on men alone. No woman or girl has ever, in any land been made a member. It is not a secret society, but it very simply organized, and has no admission fee. Each member takes the following fivefold obligation: I.....

PROMISE BY THE HELP OF GOD

1.- To treat all women with respect, and endeavor to protect them from wrong and degradation.

2.- To endeavor to put down all indecent language and coarse jests.

3.- To maintain the law of purity as equally binding upon men and women.

4.- To endeavor to spread these principles among my companions, and to try and help my younger brothers.

5.- To use every possible means to fulfil the command, "Keep THYSELF pure."

Leaflets, the object of which is to impress the reasonableness and sacredness of these promises, are circulated among the members, and occasional sermons and addresses given under the auspices of the White Cross Society, which consistantly seeks to recruit new members and to spread its blessed propaganda. Definiteness of purpose based upon intelligent and educated choice, added to the inspiration of *esprit de corps*, are the results secured by these simple methods for enlisting and enrolling our young men. Good men sign for good example's sake, just as we all sign the pledge of total abstinence from intoxicating drinks. But be it carefully noted that the *White Cross pledge can be grafted upon existing societies* of approved character. A teacher may give this pledge to the male members of his class, whether in Sabbath School, High School or College. A pastor may hold a meeting for the purpose and recommend the pledge to the young men of his church and congregation; a temperance society of men (or the men in a mixed temperance society) may take this pledge; a Knight of Labor Lodge may have its "inner circle" where this pledge is taken and its accompanying literature read and distributed. But these members must not be under sixteen years of age.

"THE SILVER CROWN" was organized last year (1886), and the following pledge, prepared by Dr. De Costa, has been adopted as the pledge of this new society, whose members are known as "Knights of the Silver Crown."

THE SILVER CROWN

Take Silver and make Crowns. Zech. 6:11.
I will refine them as silver. Zech. 13:9.
I.....

PROMISE BY THE HELP OF GOD

1.- To treat all women with courtesy and respect, and to be especially kind to all persons who are poorer or weaker or younger than myself.

2.-To be modest in word and deed, and to discourage profane and impure language; never doing or saying anything I should be unwilling to have known by my father or mother.

3.- To avoid all conversation, reading, pictures and amusements which may put impure thoughts into my mind.

4.- To guard the purity of others, especially of companions and friends, and avoid speaking or thinking evil.

5.- To keep my body in temperance, soberness and chastity.

This is for boys, and like the White Cross *is not a secret society.*

THE WHITE SHIELD

is the name chosen for the women's pledge, which is as follows, and was unanimously adopted by the Minneapolis Convention:

I.....

PROMISE BY THE HELP OF GOD

1.- To uphold the law of purity as equally binding upon men and women.

2.- To be modest in language, behavior and dress.

3.- To avoid all conversation, reading, pictures and amusements which may put impure thoughts into my mind.

4.- To guard the purity of others, especially of the young.

5.- To strive after the special blessing promised to THE PURE IN HEART.

The White Shield literature is being prepared and will cover all the points enumerated in the pledge. (Send to Woman's Temperance Publication Associations, 161 LaSalle Street, Chicago, for Bulletin.)

It is hoped that all members of the W.C.T.U. will take this pledge as an example to our younger sisters, and that mothers will carefully train their daughters in its precepts and the reasons on which they are based; also that teachers in Sabbath school, public school and college will do the same. Quietly and with prayerful wisdom this work should go forward, basing all its motives upon the gospel of a pure temple in which the soul may work out its God-given destiny on earth, and carefully avoiding any approach to such recitals as will either develop an unhealthy appetite for more, or induce a nervous excitability and morbid conscientiousness equally to be deplored.

Under wise and conservative management the White Shield may be a mighty power for the protection of young women, and to this end let the work be entered upon with a prayerful solemnity commensurate with the delicacy and importance of the undertaking. This line of effort *does not* contemplate the forming of separate societies, but only the "inner circles" of women as described for men, under the head of the White Cross.

MOTHERS' MEETINGS.

This subdivision of the general Department is under the special care of Mrs. Dr. J. H. Kellogg[E], Battle Creek, Mich., who will send her list of topics on application. We are preparing a series of leaflets to go with this list, and intended for reading and as a basis of discussion at the meetings. Here the White Shield Pledge should be circulated with its accompanying literature, now being prepared. The Silver Crown Pledge *(for boys)* should be under the special, fostering care of the Mothers' Meeting, a committee of our best, wisest and most motherly-hearted women being chosen to superintend the circulation of these

pledges. Let it be carefully noted that the woman's pledge does not involve the formation of a society. That of the boys *may*, but the two classes should *never* be addressed in the same audience, and it is better to have no public meetings connected with the work among girls. Quietly circulate among them one of the two pledges for women with the literature, delicately and carefully written, that accompanies them.

DAUGHTERS OF THE TEMPLE.

Dr. DeCosta has, with the advice and co-operation of this Department, drawn up a card headed "Daughters of the Temple" containing, like the other cards, a fivefold pledge.

That our Daughters may be as the polished corners of the Temple. Ps. 144:12.

Ye also, as lively stones, are built up a spiritual house. I. Peter 12:5.

I.....

1.-To reverence all sacred things, and to be modest is language, behavior and dress.

2.-To repress all thoughts, words, and deeds which I should feel ashamed to have my parents know.

3.-To avoid all conversation, reading, pictures and amusements, which may put wrong thoughts into my mind.

4.-To guard the purity and good name of others, especially of my companions and friends; never needlessly speaking evil of any, especially when they are absent.

5.-To strive after the special blessing promised to THE PURE IN HEART.

[This covenant is for girls under sixteen.]

The cards for boys and girls may be used at such as parents age deem best, [*sic*] and at sixteen the Juniors may be advanced to the higher department. The Silver Crown is regarded as auxiliary to the

White Cross. Societies may be formed when desirable under the leadership of clergymen or Christian men of experience, but no society of girls is contemplated.

REFORMATORY WORK.

This is to be carried on by the establishing of cheap Reading Rooms and Lodging Houses for women in large cities and towns with notices posted up in depot waiting rooms, advertising the same to the stranger and the friendless; Industrial Homes to be founded by the State as a sequel to petitions circulated by our societies; and a "Life-Saving Station" (*i.e.* W.C.T.U. Committee of two) should be formed in every local union to inaugurate and carry out reformatory work. In each community there are women especially interested in this department of Christian endeavor who can be induced to act on this Committee. Evangelistic work should accompany all these efforts. Visits to degraded women, and prayer with and for them, should be constantly made, and efforts to win them to a true life should be accompanied by practical attempts to find them honorable employment, or return them to their homes. Dr. Kate Bushnell[F], Evanston, Ill, National Evangelist of this Department, will upon request, send her circular with further details.

LEGAL WORK.

The following petition is now in circulation in nearly every State except Massachusetts and Colorado, which have already, in response to petitions of the W.C.T.U., raised the age of consent to eighteen years. Wisconsin also has laws which largely anticipate the legislation herein asked for:

PETITION.

To the Senate and House of Representatives:

The increasing and alarming frequency of assaults upon women, and the frightful indignities to which even little girls are subject, have become the shame of our boasted civilization.

A study of the Statutes has revealed their utter failure to meet the demands of that newly-awakened public sentiment which requires better legal protection of womanhood and girlhood.

Therefore we, men and women of -----, State of----, do most earnestly appeal to you to enact such statutes as shall provide for the adequate punishment of crimes against women and girls. We also urge that the age at which a girl can legally consent to her own ruin be raised to at least eighteen years; and we call attention to the disgraceful fact that protection of the person is not placed by our laws upon so high a plane as protection of the purse.

The United States Congress will be appealed to by similar petitions at the present session. A Bill to meet the requirements of these petitions has been prepared, with the advice of the best legal minds and of thoughtful men and women well qualified to deal with this difficult subject. This bill has been sent to every State and Territory, except those which have already passed the desired laws.

The term "age of consent" has been much objected to by white ribbon women, and it is suggested--after taking legal advice--that "age of protection" meets the [need] and is less objectionable.

We reiterate the urgent request to *each local union* [for] the appointment of a Superintendent of the Department for the Promotion of Social Purity.

Some have preferred to call it "Department of G[ospel] Purity," and surely the name has great significance. The good-news of purity according to Gospel (i.e., [*New*] *Testament*) standards is what we would help to [spread] abroad. Christ's "Neither do I condemn thee, *go sin no more*," proclaimed along with his "Let him [who] is without sin among YOU cast the first stone at [illeg.] are the firm basis of that *equal chastity* which Christianity equally requires of man and woman.

FRANCES E. WILLARD, *Nat. Supt. Social Purity*
MRS. J. H. KELLOGG, *Supt. Mothers' Meetings*
DR. KATE BUSHNELL, *Nat. Evangelist.*

  

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A. Willard is referring to the Criminal Law Act, which was passed in Britain in response to the public outcry following William T. Stead's exposé of white slavery in "The Maiden Tribute to Modern Babylon," published in the *Pall Mall Gazette* in 1885. The Act raised the age of consent from thirteen to sixteen.

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B. Between 1864 and 1869 the British Parliament passed a series of Contagious Diseases Acts which regulated, rather than abolished, prostitution. Josephine Butler carried a manifesto signed by two thousand prominent British women to Parliament in 1870, and she and her sympathizers succeeded in having the acts repealed. American women active in the social purity movement greatly respected Butler's work.

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C. Ellice Hopkins was a British purity reformer who publicized the age of consent issue in her 1883 pamphlet *Social Wreckage*. She advocated preventive social work to save working girls from falling into vice and prostitution.

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D. Benjamin De Costa was an Episcopalian minister from New York who began the White Cross Army, patterned after the Church of England's society, in 1885.

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E. Dr. and Mrs. James H. Kellogg accepted the superintendency of the WCTU's Department of Social Purity in 1885. They also ran a sanitarium in Battle Creek, Michigan, and invented breakfast cereals as their contribution to diet and health reform. A simple diet, many reformers believed, would keep the sexual appetite in check.

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F. Dr. Kate Bushnell was a W.C.T.U. missionary who provided sensational reports about the system of white slavery that existed in Michigan for the *New York World*. For more on the Michigan vice camps, see Document 8.

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Document 8: Bessie V. Cushman, "Another Maiden Tribute," *Union Signal*, 17 February 1887, pp. 8-9.

Introduction

In 1885, British journalist William T. Stead arranged to buy a young English woman from her parents and subsequently published an account of "white slavery" in England's *Pall Mall Gazette*. Although Stead had sent the child to safety, he was arrested on a charge of abduction and was sentenced to three months in prison. His martyrdom stirred the British conscience and led to a mass movement to abolish white slavery and protect young womanhood through raising the legal age of consent for girls to sixteen. American purity reformers watched carefully and were shocked to discover that the age of consent in most of the United States was even lower than that in England. American reformers attempted to garner the same public support as Stead had been able to do, and Bessie Cushman even borrowed the name of Stead's article in her attempt to expose the system of prostitution in effect in lumber camps in Michigan. Her article, however, failed to provoke the kind of response that Stead's exposé had in England.[9]

ANOTHER MAIDEN TRIBUTE.

———————

The modern Babylon is not limited by geographical site or boundary. "For by the wine of the wrath of her fornication all the nations are fallen." A few days ago the wires grew hot under the following dispatch relative to the female slave trade carried on between the lumber districts of the Upper Peninsula of Michigan and American and Canadian cities.

"In the new settlements the trade in young girls seems to be an established business. Advertisements cunningly devised, are used in coaxing working girls from their homes. The girls are kept in rough board shanties or tents. There are a dozen or more in each place. A system of fines is in vogue by which the poor wretches are kept constantly in debt to the overseers.

"Dogs are kept to guard against the girls running away. In one case, which has been fully investigated, a girl escaped, after being

shot in the leg, and took refuge in the swamp. Dogs were let loose on her trail, and a gang of overseers started after her. She slept in the swamp one night, but was finally hunted down and taken back to the den.

"I personally investigated the way in which a Chicago girl of undoubted respectability was kidnapped. She was decoyed from an honorable life by an advertisement offering large wages in a boarding house. When she had nearly reached her destination, she for the first time learned the horrible life she was going to, and sought to turn back, but was compelled by force to go on."

John read this to his wife, between sips of coffee, remarking: "The papers couldn't live without a little spice of this sort once in a while." Such is the reputation for veracity possessed by the American newspaper.

Mary answered: "But wouldn't it be terrible if it should be true?" and her husband, by this time deep in the reports of the Board of Trade meeting, replies without looking up, "What? Oh yes." Such is the stolidity of the American reader, exceeding that of the English when the subject is one in which he has no moneyed interest. An enterprising reporter proceeded to investigate the statement. Gaines, charged with abducting the Chicago girl, who, of course, would know most about it, is, unfortunately, out of the city; but the man in care of his place and 111 South Halsted Street, assured the representative of the press that "Minnie knew just what she was going to up there." This interview was duly published, and John again reading the morning paper says: "Here's a denial of that kidnapping canard I was reading you a couple of days ago."

Mary answers, "I'm glad there's no truth in it." The ripple in the moral sentiment of heart and home and community is smoothed away. It was pronounced an exaggerated account of an every day occurrence. Men said, "Every time the police raid one of these houses some girl tells a pitiful tale." God help them, how can any one of them tell other than a pitiful tale? This is not fiction. The denial was received as if it came from as reliable a source as the charge, so willing is conscience to receive an anodyne, so largely is the morning news taken without salt or reflection. The charge was preferred by Hon. Bartlett Breen, the member from Menomonee in the Michigan legislature. The "denial" came from a scullion in the employ of Gaines the saloon keeper and brothel keeper, and who has a "place" in

Chicago, another in the lumber districts of upper Michigan, and his "own place" in a region seldom mentioned in polite circles. Your correspondent attempted an investigation from the other side by correspondence with Representative Breen as to the truth of the statement ascribed to him, and the remedy, if the evil exist. His reply is direct.

"These vile dens and the vice they foster is the curse of our country. Prostitution is undermining society. The only remedy I could see was to get a bill through the legislature imposing severe penalties upon the keepers of disreputable places. Heretofore the punishment in this state has been a year in the county jail or $300 fines. I introduced a bill making the penalty five years in the penitentiary. It has passed and will take immediate effect. Under this law, if the authorities do their duty, and in our part of the state they will, we can suppress this terrible evil."

The "new earth" tarries for a legion of citizens who shall say in quietness and assurance, "Our officers will do their duty" and that means that only such will be put in power. Michigan has risen up and given us a glimpse of the great abomination she is about to eject. What are we going to do about it? That is the most practical question ever taken upon mortal lips. Legal suasion is the right arm of reform, but without scientific suasion which wins the consent of the mind, reform is a body destitute of brain, and without the all-permeating suasion of Christ's regenerating gospel, it is a body without heart and blood. Into these lumber camps must go the missionary of the White Cross, bearing the Bible in one hand and a text book of physiology and hygiene in the other, and a copy of the revised statutes of the state of Michigan about him somewhere, for use in extreme cases. We have seen and heard of this offset of perdition; shall we go our way and straightway forget the horrible vision, or shall we consider that wherever, in lumber or mining camps, or under any conditions, men are aggregated together, without Christianizing and refining influence then they revert toward barbarism, and there we may infer that the worst forms of prostitution will be found? The W.C.T.U. may cause to be lifted up in all such places, the glitering White Cross, by distributing its literature and inculcating the doctrine of purity as both possible and advantageous to men. We can penetrate the "vile dens," or if we come upon a place we may not enter, our wits will help us to learn the reason, and to uncover the iniquity, and discovery itself is remedial. We shall find stalwart men to help us in securing better legal enactments, as our canvassers for the social purity petition

everywhere testify.

Meanwhile we must devise some way of warning young girls, especially those of the working classes, against the snares of the decoyer, offers of high wages for services at distant points, should be regarded with suspicion and subjected to thorough investigation. Possibly no more immediate duty devolves upon the social purity department of the W.C.T.U. than the issuing and distributing among working girls a "note of warning," cautioning against the dead falls of the procurer. Let it be published on manilla paper, and so cheap that the poorest--all are poor--can afford to do their duty.

Bessie V. Cushman, M.D.

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Document 9: Petition from the Woman's Christian Temperance Union for the Protection of Women to Congress, May 1888, HR50A-H13.5, Records of the House of Representatives, Box 147, National Archives and Records Administration, Washington, D.C.

Introduction

The WCTU circulated petitions in many states as part of a national campaign to raise the legal age of consent. Historian Mary Odem argues that the campaign found its fiercest supporters among white, middle-class women, like women in the WCTU, because they believed that male vice was solely responsible for female moral downfall. The age-of-consent campaign allowed these women to challenge male privilege and the sexual double standard.[10] The following document is an example of a petition, in this case from women in Michigan, sent to Congress to influence lawmakers on this issue. Petitioning was one of the only political outlets for women, as they were typically denied the right to vote.

View Image of Original Document

N.B.--Attach paper for signatures. Print in local papers; get editorial in favor; urge that petition be clipped from the paper and circulated.

PETITION OF THE

Woman's Christian Temperance Union

FOR THE

PROTECTION OF WOMEN

To the Senate and House of Representatives:

The increasing and alarming frequency of assaults upon women, and the frightful indignities to which even little girls are subject, have become the shame of our boasted civilization.

A study of the Statutes has revealed their utter failure to meet the demands of that newly-awakened public sentiment which requires better legal protection for womanhood and girlhood.

Therefore we, women of Chesening, State of Michigan, do most earnestly appeal to you to enact such statutes as shall provide for the adequate punishment of crimes against women and girls. We also urge that the age at which a girl can legally consent to her own ruin be raised to at least eighteen years; and we call attention to the disgraceful fact that protection of the person is not placed by our laws upon so high a plane as protection of the purse.

NAMES	(Signed Names)	**RESIDENCES**
Mrs. M. J. Bennett		**Chesening[A]**
Mrs. S. M. Gildrirer		**Chesening**
Mrs. R. Wiernan		**Chesening**
Mrs. J. G. W. Adams		**Chesening**
Nettie Burt		**Chesening**
Mrs. A. S. Burrow		**Chesening**

* * * * *

I wrote for this petion [*sic*]

two months ago but failed
to get an answer for the
reason that the one I
wrote to was sick &
could not write herself.[B]

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A. This petition was signed by about 400 people.
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B. This note appeared in the lower right margin of the first page of the petition. It is unclear who wrote it.
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Document 9a: Petition from the Woman's Christian Temperance Union for the Protection of Women to Congress, May 1888, HR50A-H13.5, Records of the House of Representatives, Box 147, National Archives and Records Administration, Washington, D.C.

[N. B.—*Attach paper for signatures. Print in local papers; get editorial in favor; urge that petition be clipped from the paper and circulated.*]

PETITION OF THE

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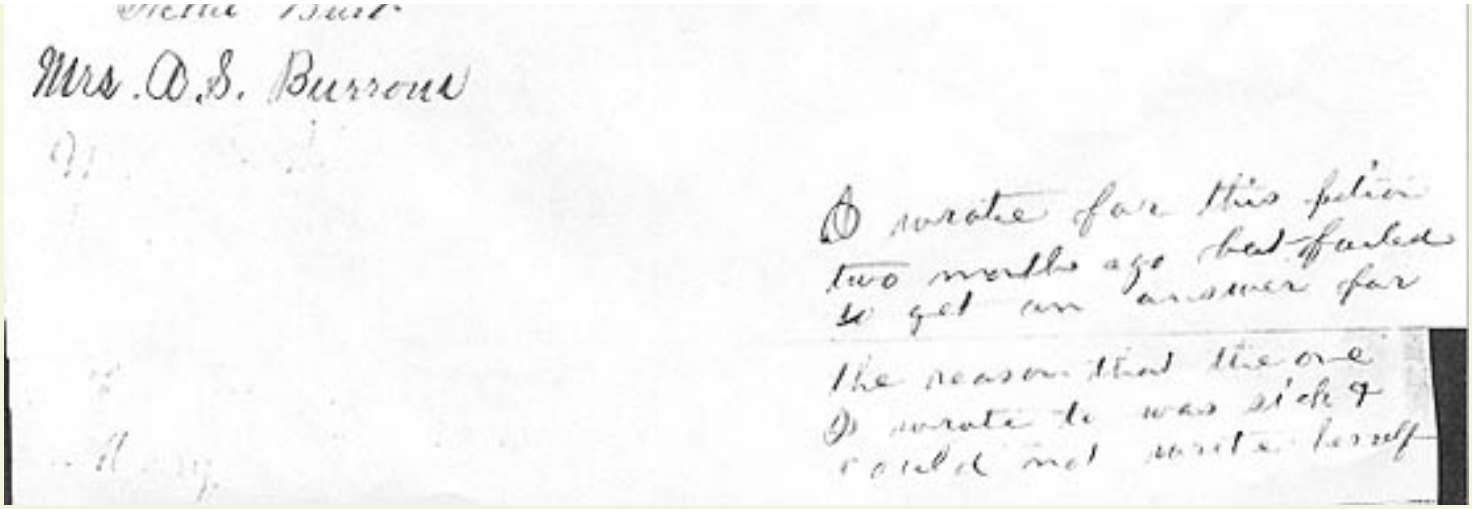
A study of the Statutes has revealed their utter failure to meet the demands of that newly-awakened public sentiment which requires better legal protection for womanhood and girlhood.

Therefore we, women of [illegible] County, State of Michigan; do most earnestly appeal to you to enact such statutes as shall provide for the adequate punishment of crimes against women and girls. We also urge that the age at which a girl can legally consent to her own ruin be raised to at least eighteen years; and we call attention to the disgraceful fact that protection of the person is not placed by our laws upon so high a plane as protection of the purse.

NAMES.	RESIDENCES
Mrs. H J Bennett	Chesaning
Mrs. S. M. Gilchrist	Chesaning
Miss. R. Wiseman	" "
Mrs. E. D. W. Adams.	
Nettie Burt	



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Document 10: "Seduction a Felony," *Philanthropist*, 3 (September 1888), p. 4.

Introduction

This anonymous article reiterates the seduction story so prominent in social purity literature in the 1880s and 1890s that portrayed men as sexual predators and working girls as victims. Reformers often used a comparison of the theft of a girl's virginity with the theft of her money to make their case for raising the legal age of consent, arguing that the former was much worse and yet not legally punishable.

SEDUCTION A FELONY.

———————

Crimes against women and girls are of such frequent occurrence as to render obvious the urgent need or more adequate legal protection for womanhood and girlhood. Progress has been made latterly in this and several other states, in raising the "legal age" of consent, in cases of rape, from ten to sixteen years; in others to thirteen and fifteen; and in two or three states to eighteen. But, alas! In many states the legal age of protection is still at the shockingly low period of ten years, and in Delaware at SEVEN! One of these is Maryland, and a lady writing from Baltimore, mentions a recent case of a lovely young girl, the daughter of a poor widow, betrayed by one who should have been her protector, and when her friends determined to make an effort to have her destroyer brought to justice, and carried the matter to the court, they were coolly informed that nothing could be done, because the girl was over *ten* years of age. Another lady, writing from Ohio, says: "Even here; in our rural districts, we repeatedly mourn over instances of neglected and unprotected girlhood, and we have *no recourse* to law in case of *seduction*."

In the state of New York, and most others, there is no penalty for seduction, except in cases of breach of promise of marriage. A man who would be subject to arrest and imprisonment if he should rob a girl or woman of her pocket book, may with comparative legal impunity seduce her and despoil her person. Libertines not unfrequently boast of the number of their sensual conquests. The loss of money is a trifling matter, compared with the loss of purity and honor. It is quite time that seduction as well as rape, should be made a punishable

offense, and, as a felony, that it should legally subject men guilty thereof to both imprisonment and fine. Nor in this particular should men alone be held amenable to law. It sometimes happens that evil disposed women victimize young men and boys and lead them into vicious pathways. Such women should also be placed under legal restraint.

Of course we do not expect law wholly to take the place of right moral training for the individual, and a right popular education concerning an equal standard of morality for both men and women. It is, however, clearly within the proper province of government as declared by Mr. Gladstone, "to make it easy to do right and difficult to do wrong."

In the forthcoming legislative season we hope a general and an effective movement may be inaugurated and prosecuted by women, and by true and honorable men to secure legislation which shall everywhere brand and punish seduction irrespective of age, a felony and crime.

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Document 11: Helen Campbell, "Poverty and Vice," *Philanthropist*, 5 (May 1890), pp. 2-3.

Introduction

Helen Campbell, a reformer and journalist who was deeply interested in social purity work, played a key role in connecting the problems of poverty with lax sexual values and crime. Historian David Pivar argues that purity reformers never resolved the tension between their view of prostitution as a crime and their view of prostitution as a social evil resulting from poverty.[11] Campbell argued strongly for the latter view, arguing that "vice is the natural air of the slums . . . [and] it must remain so till slums become impossible, and larger ideals have been made the portion of those held to-day in chains."

POVERTY AND VICE.

———————

BY HELEN CAMPBELL

———————

There are a few sayings which have been more thoroughly perverted from what we may believe to have been their original significance than the words constantly quoted; "The poor ye have always with you." Generations of strenuous acting out the theory that the salvation of the rich is to be bought by copious alms-giving to the poor has culminated in crystallization, and through the amber of charity we see the pestiferous life within, no less offensive because shut from direct contact by this fair product of nature and art.

We accept poverty as inevitable for our first premise, and proceed to frame a second no less disastrous in its effects, viz., that poverty, save where positive crimes is associated with it, is, in some sort, a virtue, and thus a surer passport to heaven than any held by the prosperous. For this conviction we are indebted among others to Mrs. Hannah More[A] and her school, which for this generation has found voice in "Ministering Children," and other popular stories for young and old, all intensifying the conviction just mentioned, that virtue is easier

for the poor than for the rich. The immortal shepherd of Salisbury Plain, for example: who can forget the glow of sympathy with which we read long ago the words in which is chronicled his soul-felt satisfaction that salt has been given for his potatoes when the potatoes of myriads more deserving were saltless. Analyze the story and hundreds of its kind, and for each and all is the lesson in contentment very beautiful for the rich to gaze upon, but vicious to the core in its effect for both. Only out of wants and ever-increasing wants can progress be born, and it was the death of progress that spoke in every word of the gospel preached by this school.

Granted at once that there are certain conditions in life which it may be counted in great degree true that poverty and virtue are close neighbors if not synonyms. But they are conditions very remote from anything we must deal with in our crowded cities and towns. Long ago, a world-weary but very worldly-wise old king wrote from his watch tower in Jerusalem, "The destruction of the poor is their poverty."

Each one of us to whom the interior of a Fourth Ward tenement house has become familiar, knows how literally true that is, and what actual destruction of moral fibre is in the fact of having been born into such atmosphere. There are moral microbes no less than the physical ones with which we have lately been contending. Their entrance is no less insidious and no less certain and their action infinitely more fatal than "la grippe" and its effects.

Take the life that must be lived from hour to hour in one of those tenements, where the least competent and thus most wretchedly paid laborers of many orders are massed. Two rooms are comparatively luxurious. For many there is but one, and in this one, there may be not only the family proper, but lodgers who take their stipulated share of the floor, and thus add to the family income. Old and young, every relation of life; every fact that is bound up with mere bodily existence and its demands, is practically promiscuous. Baby eyes see--baby ears hear from the beginning of conscious existence, all the foulness born of dirt, over-crowding, want and privation of every nature. Lust in its lowest phase:--the animal want of creatures not yet evolved from the animal, is the chief form of satisfaction known, and with it is foulness which Zola himself might hesitate to depict. It cannot be said to be deliberate choice. It is rather the inevitable result of abominable conditions and the miracle is that any virtue of any order can remain.

Taking the next phase where two or more rooms are possible,

there is still small margin for the decencies. Personal cleanliness is well nigh impossible: there is no space for what to us are the essentials of the simplest living. The child of the ordinary family under these conditions fares a trifle better than the order next below, but only a trifle. The poison is in the air. Every stairway and hall--even every shadowy place in the narrow streets has its revelation for the young eyes, and its hideous words for the young ears. One cannot exaggerate the picture. On the contrary, only individual experience can take in its full loathsomeness, and realize the life inevitable for thousands.

Out of this beastliness what shall be born? What but beastliness? We are not responsible we say, yet we allow this hot-bed of iniquity to spread its bounds and yield its natural fruit as it will. So long as these conditions remain untouched; so long as herding is, in the nature of the present order, inevitable, so long as the underlying facts of natural life are ignored and untaught, so long the Society for the Prevention of Vice will continue to lop branches and leave the roots untouched. Nor, indeed, have we much right to touch them till we are ready to admit that if all that feeds brain and spirit is denied, instinct and flesh will have its way.

With a thousand resources, a thousand methods of enjoyment and growth, man knows no stronger master than this passion. How, then, when resources are unknown , and growth, in any life they have learned to live well nigh impossible, shall we judge them, or wail over the morals of the poor? It speaks much for human nature that even here one may find clean souls untouched by the filth of their surroundings. But what right have we to subject any soul to such test, or to judge, if weaker ones cease to struggle, and yield to their environment? Ages have already passed since the evolution of the animal into the human began, and the human struggles still, and must increasingly struggle against the pull backward and downward.

Civilized as we count ourselves, vast as is the gulf between us and the beginnings of man's history, there are yet barbarisms that reproduce it, and beyond all is this life of the slums in this nineteenth century. No matter what battle may be fought, such poverty, with its attendant helplessness, must mean vice, nor can this fact alter till its farther existence is rendered impossible.

With methods to this end there is no room to deal here. Those who read this are all workers, and workers of long experience, who

know what terror lurks in this darkness, and what powers of evil must be fought. All I would do now is to emphasize this one fact: That vice is the natural air of the slums, the natural accompaniment of extreme poverty. By every law known to the development of man, it must remain so till slums become impossible, and larger ideals have been made the portion of those held to-day in chains, not to be broken save by that larger wisdom known as yet chiefly to the dreamers.

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A. Hannah More (1745-1833) was an English playwright.
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Document 12: Elizabeth Cady Stanton, "Preface," in Helen Hamilton Gardener, *Pray You Sir, Whose Daughter?* (Boston: Arena, 1892), pp. v-x.

Introduction

Elizabeth Cady Stanton (1815-1902; see biographical sketch in male supporters of woman's rights project, also on this website), a woman suffragist and writer, believed that the movement to raise the legal age of consent was a necessary precondition to equality between the sexes. She wrote the preface to Gardener's novel about a fourteen-year-old clerk in a department store who first was seduced by the married manager of her store and then died a lonely death. Historian Mary Odem argues that "Gardener's seduction narratives . . . express female reformers' deep anger about women's sexual vulnerability in a male-dominated society."[12] Stanton's introduction makes clear the connection woman suffragists made between the need to raise the age of consent and the emancipation of women. For this reason, the social purity movement counted woman suffragists among its staunchest supporters.

Preface

In the following story the writer shows us what poverty and dependence are in their revolting outward aspects, as well as in their crippling effects on all the tender sentiments of the human soul. Whilst the many suffer for want of the decencies of life, the few have no knowledge of such conditions.

They require the poor to keep clean, where water by landlords is considered a luxury; to keep their garments whole where they have naught but rags to stitch together, twice and thrice worn threadbare. The improvidence of the poor as a valid excuse for ignorance, poverty, and vice, is as inadequate as is the providence of the rich, for their virtue, luxury, and power. The artificial conditions of society are based on false theories of government, religion, and morals, and not upon the decrees of a God.

In this little volume we have a picture, too of what the world would call a happy family, in which a naturally strong, honest woman is

shriveled into a mere echo of her husband, and the popular sentiment of the class to which she belongs. The daughter having been educated in a college with young men, and tasted the tree of knowledge, and, like the Gods, knowing good and evil, can no longer square her life by opinions she has outgrown; hence with her parents there is friction, struggle, open revolt, though conscientious and respectful withal.

Three girls belonging to different classes in society; each illustrates the false philosophy on which women's character is based, and each in a different way, in the supreme moment of her life, shows the necessity of self-reliance and self-support.

As the wrongs of society can be more deeply impressed on a large class of readers in the form of fiction than by essays, sermons, or the facts of science, I hail with pleasure all such attempts by the young writers of our day. The slave has had his novelist and poet, the farmer his, the victims of ignorance and poverty theirs, but up to this time the refinements of cruelty suffered by intelligent, educated women, have never been painted in glowing colors, so that the living picture could be seen and understood. It is easy to rouse attention to the grosser forms of suffering and injustice, but the humiliations of spirit are not so easily described and appreciated.

A class of earnest reformers have, for the last fifty years, in the press, the pulpit, and on the platform, with essays, speeches, and constitutional arguments before legislative assemblies, demanded the complete emancipation of women from the political, religious, and social bondage she now endures; but as yet few see clearly the need of larger freedom, and the many maintain a stolid indifference to the demand.

I have long waited and watched for some woman to arise to do for her sex what Mrs. Stowe did for the black race in "Uncle Tom's Cabin," a book that did more to rouse the national conscience than all the glowing appeals and constitutional arguments that agitated our people during half a century. If, from an objective point of view, a writer could thus eloquently portray the sorrows of a subject race, how much more graphically should some woman describe the degradation of sex.

In Helen Gardener's stories, I see the promise, in the near future, of such a work of fiction, that shall paint the awful facts of woman's position in living colors that all must see and feel. The civil and canon law, state and church alike, make the mothers of the race a helpless,

ostracized class, pariahs of a corrupt civilization. In view of woman's multiplied wrongs, my heart oft echoes the Russian poet who said: "God has forgotten where he hid the key to woman's emancipation." Those who know the sad facts of woman's life, so carefully veiled from society at large, will not consider the pictures in this story overdrawn.

The shallow and thoughtless may know nothing of their existence, while the helpless victims, not being able to trace the cause of their misery, are in no position to state their wrongs themselves.

Nevertheless all the author describes in this sad story, and worse still, is realized in every-day life, and the dark shadows dim the sunshine in every household.

The apathy of the public to the wrongs of woman is clearly seen at this hour, in proposition now under consideration in the Legislature of New York. Though two infamous bills have been laid before select committees, one to legalize prostitution, and one to lower the age of consent, the people have been alike ignorant and indifferent to these measures. When it was proposed to take a fragment of Central Park for a race course, a great public meeting of protest was called at once, and hundreds of men hastened to Albany to defeat the measure.

But the proposed invasion of the personal rights of woman, and the wholesale desecration of childhood has scarce created a ripple on the surface of society. The many do not know what laws their rulers are making, and the few do not care, so long as they do not feel the iron teeth of the law in their own flesh. Not one father in the House or Senate would willingly have his wife, sister, or daughter subject to these infamous bills proposed for the daughters of the people. Alas! for the degradation of sex, even in this republic. When one may barter away all that is precious to pure and innocent childhood at the age of ten years, you may as well talk of a girl's safety with wild beasts in the tangled forests of Africa, as in the present civilization of England and America, the leading nations on the globe.

Some critics say that every one knows and condemns these facts in our social life, and that we do not need fiction to intensify the public disgust. Others say, Why call the attention of the young and the innocent to the existence of evils they should never know. The majority of people do not watch legislative proceedings.

To keep our sons and daughters innocent, we must warn them of

the dangers that beset their path on every side.

Ignorance under no circumstances ensures safety. Honor protected by knowledge, is safer than innocence protected by ignorance.

A few brave women are laboring to-day to secure for their less capable, less thoughtful, less imaginative sisters, a recognition of a true womanhood based on individual rights. There is just one remedy for the social complications based on sex, and that is equality for woman in every relation in life.

Men must learn to respect her as an equal factor in civilization, and she must learn to respect herself as mother of the race. Womanhood is the great primal fact of her existence; marriage and maternity, its incidents.

This story shows that the very traits of character which society (whose opinions are made and modified by men) considers most important and charming in woman to ensure her success in social life, are the very traits that ultimately lead to her failure.

Self-effacement, self-distrust, dependence and desire to please, compliance, deference to the judgment and will of another, are what make the young women, in the opinion of these believers in sex domination, most agreeable but these are the very traits that lead to her ruin.

The danger of such training is well illustrated in the sad end of Ettie Berton. When the trials and temptations of life come, then each one must decide for herself and hold in her own hands the reins of action. Educated women of the passing generation chafe under the old order of things, but like Mrs. Foster in the present volume, are not strong enough to swim up the dream. But girls like Gertrude, who in the college curriculum have measured their powers and capacities with strong young men and found themselves their equals, have outgrown this superstition of divinely ordained sex domination. The divine rights of kings, nobles, popes, and bishops have long been questioned, and now that of sex is under consideration and from the signs of the times, with all other forms of class and caste, it is destined soon to pass away.

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Document 13: Helen H. Gardener, "What Shall the Age of Consent Be?" *Arena* (January 1895), pp. 196-98.

Introduction

Helen Hamilton Gardener (1853-1925) was a writer, reformer, and suffragist who was extremely active in the age-of-consent movement, regularly reporting on the progress of the campaign for the *Arena*. While initially women reformers had organized petition drives to influence legislators to raise the legal age of consent, some women, like Gardener, came to argue that the low age of consent was due to the disenfranchisement of women, and that adequate moral protection of women required that women be granted the right to vote.

II. WHAT SHALL THE AGE OF CONSENT BE?

BY HELEN H. GARDENER.

When I am asked to present an argument against lowering the age of consent, or when I am requested to write the reasons why that age should be raised to at least eighteen years, it impresses me very much as if some one were to ask me gravely, if I would be so kind as to try to think up some fairly plausible grounds upon which one might base an objection to the practice of cutting the throats of his neighbor's children whenever that neighbor happened not to be at home to protect them; or to furnish a demurrer to the act of inoculating the community with small-pox as a matter of ordinary amusement. There is not, there never has been there never can be any fact in nature that is not a protest in letters of flame against the infamy of legal enactments which place the innocence and ignorance of childhood at the mercy of licensed lechery.

To begin with, no being who is not too degraded or too utterly mentally and morally diseased to be a safe person to be at large, could wish that a little child, a baby girl fourteen, twelve, aye, ten years of age should be made as is the case in many of our states, the legal and rightful prey of grown men. There is no argument. There is no basis for a difference of opinion. No man on earth would pass or want passed such a law for his own child, for his own sister, for anyone for whom he

cared. It is too gross, it is too inhuman for words. No legislature on the earth, if its discussions were open to women, if women were present at its sessions would ever have passed such acts. No man who ever lived, no man who ever will live, could justify his vote in its favor, with his wife or his mother or his sister beside him, with his own little girl looking into his eyes. Now, legislation that is not good enough, just enough, based upon principle and honor enough to meet the open understanding and approval of the mothers of a nation, can ever result in anything but disaster for that nation.

What good can it do any human being to have the age of consent below that at which honorable marriage, or the right to sell property comes to a girl? Who is to profit by it? Surely not that girl, since by her immature "infant" judgment she has wrecked her whole life, while the law protects her against her "infant" judgment in immaturely squandering or deeding away her property. Who is to profit by it? Whom is it intended to benefit? There can be but one answer. It is a law in the interest of the brothel, in the interest of the grade of men who prey upon the ignorance and helplessness of childhood.

"Ah, but," says one, "there are wild and bad and perverted girls, who would lay traps for inexperienced boys, who are not over eighteen years of age, and by threats thereafter blackmail them into marriage." That is the only attempt at an argument that I have ever heard on that side of the question. It is easily answered. Let the boy and the girl stand upon precisely the same legal footing. Let the law not favor her in the least. Let it not hold him, anymore than it does her, to account in such a case. Where both are children, "infants before the law" let both be treated as children and give no legal advantage to either.

But this plea is and has always been a mere blind subterfuge. Such cases are too rare to demand very serious consideration. It is not, and it never has been to protect the lads who may be led into indiscretion by designing young girls that such laws were made. It is to shield men of mature and vicious lives from the results of their most heinous vices. It is to cater to crime against the baby girls of the lower and middle classes of the race, and to foster the vilest traffic that was ever known to human beings that men who are our fathers and brothers have met in secret session and framed and passed such laws--sessions so secret that even some of the members of the legislatures themselves after years of service for their states, assure us that they personally never even dreamed that such laws had been enacted by their own body and that they disgraced the statute books of their

states.

But if there are good and legitimate reasons (of which I am ignorant) for such legislation; if there is a member of any legislature of any state who honestly believes that he is justified in voting for such a law, there are many thousands beside myself, both men and women, who would be glad to have him present his case. I therefore ask with the permission of the editor of THE ARENA, that any legislator of any state who believes that he has a right to help to retain the age of consent below that at which a girl may legally dispose of property, will clearly set forth, over his own name and in appropriate language, his reasons for such a belief, whether these reasons be of a religious, scientific, social or legal nature, and I will respond to them, and leave the verdict in the hands of the readers of THE ARENA. If no legitimate and convincing argument can be advanced, if there is no open champion who can present a legitimate reason for passing and sustaining such laws, then surely we may demand their immediate repeal in every state.

Recent information from one of the states says: "It [the bill to raise the age of consent] was introduced into the same senate and debated during one whole afternoon *behind closed doors and for men only.* It was not even allowed to go to the lower house, but was defeated right there." If there is enough to say in favor of such a measure to take up the debate of one whole afternoon, there is surely enough to form one magazine article. Its champions are now requested to respond.

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Document 14: Emily Blackwell, "Age of Consent Legislation," *Philanthropist*, 9 (February 1895), pp. 2-3.

Introduction

Emily Blackwell (1826-1910) became a physician like her sister Elizabeth, who had been the first woman in America to receive a degree as a doctor of medicine. The two women directed the New York Infirmary for Women and Children and the Women's Medical College, which in addition to providing medical services for women, also offered advanced training for women physicians. Both women were leaders in the social purity movement. Emily Blackwell teamed with Aaron Macy Powell to initiate and lead the petition campaign to raise the age of consent. In the following article, reprinted in the *Philanthropist* from the *Arena*, Blackwell highlighted the view that poor working women were in danger because they lacked parental protection, and connected as well the need for legislation to raise the age of consent to the woman suffrage movement, underscoring the link between the woman's and social purity movements in the late nineteenth century.

AGE OF CONSENT LEGISLATION.

BY EMILY BLACKWELL, M.D.

By fixing the age of legal majority the State declares that under this age young people have not the experience nor the maturity of judgment which would qualify them for independent action in matters of importance affecting their own interests. They are in consequence made incapable of such action. Their consent cannot relieve a guardian from responsibility in the management of their property. Except in a few exceptional cases they cannot make a contract which will be binding when they come of age. A minor cannot legally marry without the consent of the guardian. Surreptitious marriage with a minor is an offense punishable by law, and such a marriage can be annulled upon the application of the guardian. Thus their power of action is, in their own interest, so limited that their consent is not sufficient to make valid even perfectly legitimate transactions, nor does it avail to protect adults who assume it as sufficient authority.

Even in crime youth is allowed as an extenuating circumstance, from the general feeling that the young are less able to resist external influences, and are less responsible for their actions than the adult. The establishment of reformatories for juvenile offenders testifies to the belief that their characters are still unformed for good or for evil.

In the case of girls, the State has not only extended exceptional protection to them as minors in reference to their legitimate social relations, it has also established a sort of legal majority in reference to those that are illegitimate. It has fixed an age below which girls are held to be incompetent of assent to such illegitimate relations. "Consent," as it is termed, varied in all the different States, until recently, from the age of seven to twelve years, and in many of them it is still only ten or twelve. This arrangement amounted virtually to the protection of children only for the years during which their physical abuse is so brutal an offense as to excite indignation even among the majority of persons of vicious life. The protection accorded in other respects to minors was distinctly and emphatically withdrawn from girls during the first few years of early womanhood, when it is most needed.

Such legislation is directly in the interests of vice. The line is drawn just where those who are interested in vice would have it. It is certainly as illogical as cruel that an age when a girl's consent is not held sufficient for legal marriage, it should be held sufficient to justify her destruction. A man may not legally marry the minor daughter of another without his consent, but he is legally free to seduce her if he can.

It would seem that our present legislation was influenced more by respect for property, than by consideration for personal protection. Virtually it is effective only in regard to the well-to-do class in which property considerations enter largely into the question of marriage. In this class the daughters live at home, under the protection of parents and family connections, to mature age. The only danger to which they are actually exposed is to that of an imprudent marriage, and against that the law fully protects them.

The case is entirely different with the majority of girls where poverty obliges them to go to work as soon as they are capable of earning. Ignorant, inexperienced, impulsive, they enter the great world of work, usually into wearisome and ill-paid labor, under the control and direction of men. For except in domestic service, girls do not come much in contact with the great body of respectable elder women who

should be their natural guides. These are withdrawn from their world of industry, and are occupied in domestic life, and those whom the girls do meet in work are usually not in positions of influence or authority. It is with men largely that the girls deal, and upon them they depend for direction and occupation. Even in domestic service girls are removed from home life, and thrown among associates of the most varied character, and for whom the mistress usually feels little responsibility. There is no class in society so helpless, so surrounded by temptation, as young working girls just growing up. They are surrounded by a network of snares and pitfalls. For this is the class which is coveted as a prey by the licentious and by those who live by pandering to licentiousness.

Though unacknowledged and working under cover, there exists virtually an organized system of temptation, controlled by old experienced agents of vice, aiming to sweep as much of this fresh material as possible into their nets. How constant and insidious this work is, what craft and what indirect means are employed to entice young girls into some of the many devious paths that lead downward, can only be realized by those whose attention and thought have been especially called to the subject. The testimony given before the committee of Parliament in reference to the working of the Contagious Diseases Act, and in the reference to the international traffic in girls, is full of terrible testimony to the extent of youthful prostitution in great cities, to the endless ways in which the victims are tempted or entrapped, and the difficulty of escape when once they fall into bad hands. The experience of all societies that deal with the young, the history of the Michigan lumber camps[A], all tell the same story with endless variations, of the dangers which encompass these years of early womanhood on its entrance into work of all kinds outside of the home.

Society unconsciously works into the hands of the tempters. As cruelly severe toward women as it is criminally indulgent toward men in these respects, it is enough for a girl to be compromised, or even suspected, to make it difficult for her to obtain employment and keep in the ranks of the honest. The whole situation grows out of the different standard of virtue for men and women, that while chastity is the one absolute prerequisite to social consideration and even to decent life among women, it is regarded as an absolutely impossible virtue in men. Consequently seduction is a minor offense in a man--though it means destruction to the woman. Virtually a man who seduces a young woman commits a greater crime than if he killed her, as moral

death is a greater misfortune than physical death. Would not most parents consider the death of a daughter less of a misfortune than that she should take the first step toward a life of vice?

So long as the State acknowledges any special obligation toward minors in protection of property and person, it is certainly bound by duty and interest to extend it to those who most need it. To assume that a girl of fourteen or fifteen is not to be trusted in making a legal marriage, but that a girl of eleven or twelve is competent to understand and accept the consequences of an illegitimate connection, is a glaring absurdity, only to be accounted for by the different motives on which such action is based. No reason can be given for the low age of consent that would not tell equally upon every restriction on the freedom of minors. It is surely to the interest of the State that its girls should grow up virtuous women. It cannot be its interest to facilitate the work of those who would compass its destruction, in order to increase the temptations to vice, already too powerful, which surround young men.

Wherever the age of protection has been raised the result has been for good only. It acts as a deterrent upon those who would mislead youth. It strengthens the hands of the individuals and societies who work for the protection and help of friendless youth. It would seem sufficient to state the case fairly to accomplish our end, but the great long-continued effort that has been needed to partially accomplish this end testifies to the contrary. And constant vigilance is needed to keep even what is gained. Vice is always watching its opportunity. Two years ago a bill to lower the age of consent to its old standard came very near passing the New York Legislature, and was only defeated by the timely effort of a single member. It is said to be good policy to do what your enemy opposes, and there is no doubt that all the vicious element of our cities is opposed to our efforts. They recognize that our present legislation is just what is to their advantage.

It is often objected to the advocates of woman suffrage, that women can have all the legal rights they can justly claim without it, that men are always ready to remove any proved injustice to them. Yet the fact remains that the first States to raise the age of consent to that of majority were those in which women had a direct voice in politics--Wyoming and Kansas. There can be no doubt that had women a share in legislation, the present agitation would be unnecessary, for these disgraceful enactments would long ago have been erased from our statute books. Indeed they would never have been placed there in the

first instance.

So long as the State assumes any obligation on the matter, the only just and logical ground to take is that the age of consent should be raised to that for independent legal majority. -- *The Arena for January*

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A. For more on the Michigan Lumber camps, see Document 8.

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Document 15: Vie H. Campbell, "Why an Age of Consent?" *Arena*, 69 (April 1895), pp. 285-88.

Introduction

The *Arena*, a national journal founded by reformer Benjamin O. Flower and dedicated to social and political reform, focused national attention on the social purity movement and the campaign to raise the age of consent.[13] The journal published several articles in 1895 about the age-of-consent campaign because after impressive legislative gains in the first five years of the campaign, legislators in several states had introduced bills to lower once again the legal age of consent. In her article, Vie H. Campbell argued that age of consent should be abolished altogether, and that instead it should be a crime to seduce women of any age. "Moral death is a greater misfortune than physical death," she wrote. In an era when many working-class single women were embracing a freer sexual atmosphere, Campbell and some middle-class women reformers continued to place responsibility for premarital sexual relations solely on the shoulders of the male seducers, unable to admit that women possessed sexual desire or should have the right to act on those desires. Instead, reformers believed that working girls should be protected from the very leisure activities and sexual experimentation that many of these girls sought out.

WHY AN AGE OF CONSENT?

BY VIE H. CAMPBELL, PRESIDENT
WISCONSIN W.C.T.U.

The most infamous laws that stand as a blot upon our statute books to-day are those known as the "age of consent laws." They are a disgrace to America's boasted civilization, a menace to the peace of our homes and the safety of our children, a bar to our social and spiritual advancement; and they are doing more towards the maintenance of a double standard of purity than all other forces combined.

I believe that it is the duty of every right-minded man and woman to be brave, frank, and outspoken in behalf of a higher civilization, to show the people the awful downward tendency of these iniquitous

laws. It is urged by the conservative ones, those upon whose lips false modesty and false ideas of propriety have set the seal of silence, that "It is not womanly to speak of those things; it will not do for our daughters to hear about them: If we speak plainly on this subject we shall suggest the very evil we wish to cure, and thus do more harm than good." Do those who urge this objection (and they are far too numerous) ever think of the harm that has been done because we have been silent on these vital questions? Do they ever think of the thousands of young women and of young men who have gone astray, who have fallen into the awful vortex of destruction, because of their ignorance of these things, because some one who knew did not point out to them the pitfalls that awaited their unsuspecting feet? Fully one-half of the girls who fall into that life that is worse than death, fall because of their ignorance of the laws of their being and of the penalty that results from a disregard of those laws. Can we longer remain silent and be guiltless ourselves? Have we not a responsibility in this matter that we cannot afford to shirk?

It is time for the great search-light of God's eternal truth to be turned on these dark places; it is time for the seal to be removed from the lips that have so long been silent; it is time for the plain speaking to reveal to innocent, unsuspecting girlhood the snares that are set to entangle her feet. This long continued silence is the tribute which unbridled lust has demanded of us; and that we have, without remonstrance, paid it too long, the increasing army of unwarned, unfortunate, helpless victims will bear witness. Whatever may be our shortcomings in the future, let us never be guilty of the sin of silence!

Our laws are shamelessly unequal when they make the punishment for stealing away a woman's honor no greater than for the purloining of her wardrobe, or when they give the man who robs her of her character a lighter sentence than he who steals her purse would incur; but what terms are strong enough to use in their condemnation when they make little girls, ten and twelve years of age, the lawful prey of lecherous villainy? Has American fatherhood fallen so low that it is willing to have laws stand upon our statute books that protect libertines, but do not protect our little girls? Is there a man, worthy of being called a man, who believes that a little girl twelve years of age is so well versed in the world's villainies that she is able to protect herself against the wiles of designing and unscrupulous lust? And if it was his own daughter whose purity had been sullied by some wretch who had taken advantage of her innocent ignorance and had compassed her ruin, would he consider it an adequate defense if the villain should

plead that "she did not offer violent physical resistance"? And yet the men who comprise the legislatures, and profess to represent the people of five of our states--Kentucky, Louisiana, Texas, Virginia, and Wisconsin--have fixed the age at which little girls are the legal prey, to the merciless, willy debauches at twelve years! And it is always the testimony of the one who committed the crime and who is striving to escape the penalty of law, that bears the greatest weight in our courts of--shall I say, justice?

In pity and shame let it be said that those who have made laws for women and children have stamped their own degradation upon our statutes, and that the law which comes forward in its majesty to declare that the child shall be protected in her property, that she cannot make contracts in business matters, nor be united in marriage, unless she obtains the consent of her guardian, also says that she may consent to her moral, spiritual, and physical ruin; while the arch-fiend who robs her of her crown of womanhood, her virtue, is protected by these infamous laws that tend towards the moral degradation of manhood and the destruction of womanhood. There can be no argument, no excuse for such laws; they are not only barbarous, but inhuman.

These cruel laws, that have wrought such injustice to girlhood, are the heritage of a less developed, less civilized past; and they have been even more harmful to man because they have made it too easy for him to do wrong. While they have been cruelly severe towards women, they have been criminally indulgent towards men. The degradation of womanhood rises to gigantic proportions when it drags into its vortex little girls of ten and twelve years of age, and it includes also the degradation of manhood.

I believe that consenting to a crime is in itself a crime, and I hope the day is not far distant when the age-of-consent laws will be swept from our statutes. The crime that robs woman of the crown of her womanhood, her virtue, that takes advantage of her in a moment of unguarded weakness, at whatever age, is a crime before the awful magnitude of which all other crimes dwindle into insignificance. Moral death is a greater misfortune than physical death. The crime against women is one the laws of nature do not pardon; it is the crime of crimes, because it is the unanimous rebellion against the law of love, the supreme law of life, that is confirmed by all-substantial, ethical science that comprehends the true nature of mankind. We might with greater propriety, have an age at which murder, arson, or any of the

high crimes and misdemeanors could be committed, than to have an age recognized by law for this great crime.

That these laws are conducive to a double standard of purity must be apparent to anyone who gives the subject the careful consideration which its importance demands. Any form of law that excuses one from the foulest crime known to mankind, because he can take oath that his partner consented to it, serves to stimulate society to uphold him, while it makes an outcast of her.

I am well aware that I am taking advanced ground on this subject. All the agitation, thus far, has been for the purpose of raising the age of consent to the age of which a girl can legally transact business, and no steps have been taken for abolishing it; but I am fully convinced that it should be abolished, and that laws should be passed making the penalty for the crime against women a severe one. In justice to men, as well as to women, we need just laws, reinforced by the strong hand of penalty, for

> "The woman's cause is man's; they rise or sink. Together, dwarfed or godlike, bond or free."

This is an evil that poisons the springs of national life as well as those of individual life, because decay is at the heart of a nation that degrades and tramples upon its women; and wherever the degradation of woman has been most recognized, all other forms of vice and impurity have been most prevalent; impurity in the man or woman destroys the family and destroys the nation. Our moral code will never be higher than we strive to make it, therefore in behalf of outraged and wronged womanhood, in behalf of manhood that is dragged down by the reciprocal laws of nature, and whose ethical standard must be raised if the degradation of women is to cease, in behalf of innocent and defrauded childhood, I plead that all that is unjust, all that is impure, and all that makes for two standards of morals be erased from our statutes, so that our laws may be the expression of a purer people. Instead of bewailing our difficulties or imaginary obstacles, let us take the forward step that will lead to a higher and purer national life, so that we may have

> A stronger race,
> With hearts and hands,
> To till the wastes, and moving everywhere,

Clear the dark places and let in the law.
To break the bandit holds, and cleanse the land.

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Document 16: Helen Hamilton Gardener, "A Battle for Sound Morality, or the History of Recent Age-Of-Consent Legislation in the United States," *Arena*, 69 (August 1895), pp. 353-56.

Introduction

The following article excerpt focused not on a moral argument for raising the age of consent but legal and eugenic reasoning. Gardener argued that until that age when young women could legally control their own property or get married, they should not be able to consent to sexual relations. In protecting these girls against seduction, she argued, the state also protected society against dysgenic results. She wrote, "These children's lives are wrecked, and the state is burdened with disease and vice and crime and insanity, which is transmitted and retransmitted until its proportions appall those who understand." Gardener and other female reformers always portrayed these girls as victims of, in her words, "the abnormally developed sex-perversion and cravings of the dominant sex," allowing for no possibility of female sexual desire in these relationships.

A BATTLE FOR SOUND MORALITY, OR THE HISTORY OF RECENT AGE-OF-CONSENT LEGISLATION IN THE UNITED STATES.

BY HELEN H. GARDENER.

PART 1. THE VICTORY IN NEW YORK, ARIZONA, AND IDAHO.

In dealing with the question of the so-called "age of consent" (which might better be called the age of protection), I wish to state at the outset that I shall not consider it in the usual way, that is to say, as legislation in the interest of morality, *per se*. What our religious and moral views may be depends very largely upon accident of location, birth, or training, and these vary widely among equally good citizens. Nor do I believe it wise or possible to legislate morals into people. In one sense a law against theft is moral legislation; so is a law against arson or murder; but it is not *because* of the moral quality of such acts

that we make laws to control those who steal or burn or murder. It is primarily because we wish to protect against violence the property and lives of the citizens of the state. It is because property-holders object to incendiarism and theft, and all men object to being murdered; so that this moral legislation has a natural basis, inherent in the very fabric of life and citizenship, quite aside from the right or wrong of the acts from a religious or a moral point of view--a basis that is far firmer, deeper, and more universal than any one faith or than any single code of ethics.

This is equally true of the legislation sought in the interest of the girl-children of America. They have a right to legal protection of their persons, which is more imperative by far than is the protection which every state has recognized as a matter beyond controversy when applied to a girl's property or her ability to make contracts, deeds, and wills, or to her control of herself in any matters which are of importance to her as an individual, and to the state, because she is one of its citizens whose future welfare is a matter of moment to the commonwealth. The law guards girls against the immaturity of their own judgment. It says: "Until you are twenty-one years of age you may not buy or sell or deed property; you have not sufficient judgment to make important contracts, and until you have this, the law will protect you even against yourself; for this matter is of importance not only to you and yours, but to the state in which you are to be a helpful or a harmful or a burdensome unit henceforth."

This same position the state takes in regard to a girl's legal marriage. Experience shows that the children of mothers who were too young have not a fair birthright. The mothers themselves are too immature to give safe and healthy and sound children to the state. Then, too, the cruelty of immature maternity to the mother herself has been held (in the more civilized nations) as a matter of serious moment.

Now, in regard to unmarried motherhood, or prostitution outside of wedlock, the state has temporized with the abnormally developed sex-perversion and cravings of the dominant sex until the danger to the state and to society is very real and all-pervading; until famous physicians and alienists everywhere declare that "not one family in ten can show a clean heredity, free from the poison of the vilest disease known to the race"; until the "civilized" countries are filled with epileptics, syphilitics, imbeciles, sex-perverts, and consumptives, and the insane asylums expand to alarming proportions; until prisons are

crowded with criminals who were born with vice in their blood; until paupers, the offspring of outcasts, burden the state and curse--they know not what.

It is notoriously true that brothels and vice-factories get their recruits from the ranks of childhood--from the ignorance which is unprotected by law. These children's lives are wrecked and the state is burdened with disease and vice and crime and insanity, which is transmitted and retransmitted until its proportions appall those who understand. Now it is our contention, first, that these children, for and because of their own right to a fair chance in life to be well and happy and successful, are themselves entitled to protection, if need be, from even their own ignorance or desire in this matter as in matters of property, contracts, or marriage, and second, that in interest of public health and future generations, it is of vast importance to the state to protect her children in this matter also (even against their own wishes) until their own judgments may be supposed to have matured sufficiently for the state to say: "Now you must choose for yourself and *take the consequences*. If you choose now to pollute yourself and the public fountain of health, I cannot interfere, *unless* you use violence upon others, *until* you become in one form or another a public charge. With your morals, as such, I have nothing to do; but with your capacity and willingness to add to the volume of crime, vice, disease, insanity, and mortality, I *have* something to do, and I will protect myself, also. Until you were of mature age and judgment, I also protected you even against yourself."

This is the position of those of us who urge immediate legislation in every state upon the "age of consent." That most of the writers who have taken part in the agitation have not based their arguments wholly upon this scientific and natural basis is doubtless due to the fact that this form of legislation appeals strongly to many who are acoustomed to look upon all such matters from a religious or philanthropic point of view. It has been the policy of the ARENA to let each writer give his or her own views and arguments as he or she saw fit. But the state of New York struck the basic priciple and keynote when her two State Medical Associations (Allopathic and Homeopathic) passed resolutions asking for this legislation "in the interest of public health and clean heredity," in the interest of future generations as well as in that of the unfortunate children whom its protection will save from the physical hell which they do not understand is in store for them and from the social degradation which is also inevitable, and as cruel and relentless as the folds of a python.

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Document 17: Henry B. Blackwell, "The Case of Maria Barberi," *Woman's Journal*, 10 (August 1895), p. 252.

Introduction

Henry Blackwell (1825-1909), brother of Emily and Elizabeth Blackwell and husband of Lucy Stone, was a hardware store owner, abolitionist, and women's rights activist. He remained steadfast in his devotion to the cause of women's suffrage until his death. In the following article, he argued that Maria Barbieri should not be held responsible for killing the man who had seduced her, because "if every man who seduces a child of 15 leaving her no practical alternative but suicide or a life of prostitution, were promptly put out of existence, the morals of the community would be vastly improved." The piece argued against the double standard that pervaded American criminal justice.

THE CASE OF MARIA BARBERI

Maria Barberi is an Italian child, 15 years of age, reared in the slums, ignorant of our institutions, unable to speak our language, poor and illiterate. She has not yet reached the age of mental maturity. Under the laws of New York, if at any time during the next six years she should give her note or promise to pay any sum of money, the act would create no legal obligation, because she will not have arrived at years of discretion. She is a minor in the custody of her parents. A man of mature age takes advantage of her youth, her ignorance, her mental and moral immaturity. He seduces her under the promise of marriage by professions of love and affection. Then he boasts of his conquest, he degrades and repudiates her. He meets her expostulations with scorn and insult. The child's love turns to hatred. She goes wild with anger and despair. She kills him. She is found guilty of wilful murder, and Recorder Goff, at the request of the district attorney, sentences her to death.

Under Massachusetts law this girl has been the victim of a rape. With logical consistency our statute holds that a girl of 15 cannot give a legal consent to the alienation either of her property or her virtue. Under the law of every nation, civilized or barbarous, extreme

provocation and outrage are held to palliate or even to justify the fact of homicide. How is it, then, that in the case of this poor girl all such considerations are disregarded? If this sentence is carried into effect, who will be most truly guilty of the crime of murder--the seducer, the legal officials, or Maria Barberi? In the eye of reason and enlightened ethics the convicted criminal will be the least guilty of them all.

The sentence of Maria Barberi is an object-lesson for woman suffrage. To be weak is to be miserable. Had she been a man 21 years of age and a voter, or even a boy of 15 years of age, the verdict would probably have been altogether different. Had Maria been a wife and her husband the avenger, he would have been applauded for the deed, and in course of time might have been made a major-general and a hero, as in the case of Sickles. Here is the odious contrast: For a man and a voter pity and acquittal, followed by preferment; for a disfranchised woman, even though a child, condemnation and electrocution!

Such is New York justice in 1895. Clearly the Empire State is in a bad way. There is but one way to better it. Add to the voting constituency one million educated women who can read and write the English language. Then women will be respected, for power always commands respect.

It goes without saying that I do not counsel or justify homicide. But, in the present state of society, if every man who seduces a child of 15 leaving her no practical alternative but suicide or a life of prostitution, were promptly put out of existence, the morals of the community would be vastly improved. This girl has had no trial by a jury of her peers. She has been tried, convicted, and sentenced by men alone. If half the jury had been women as should be invariably the case,--if there had been but one woman connected with the trial, no such cruel sentence of capital punishment would have shocked the moral sense of mankind.

I appeal to Governor Morton, who holds the pardoning power, to rectify this great wrong. It is his official duty. He owes it to the honor of the State to see that this legal child murder shall not be perpetrated.

H.B.B.

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Document 18: "The National Colored Woman's Congress," *Woman's Era*, 2 (January 1896), pp. 3-4.

Introduction

African-American women did not embrace the campaign to raise the age of consent, because they feared that stricter criminal laws would lead to further targeting of African-American men and do little to protect young black women in the south from sexual exploitation by white men.[14] The following document, an excerpt from a longer report on The National Colored Woman's Congress printed in the *Woman's Era*, illustrates African-American women's support for social purity issues in general. However, a resolution earlier in the report that had pledged support for the work of the WCTU had also hinted at the reason underlying the women's lack of support for the age-of-consent campaign. (For more on women's activism to stop lynching, see "How Did Black and White Southern Women Campaign to End Lynching, 1890-1942?" also on this website.)

Resolved, That as the National W.C.T.U. offers so many opportunities through which the women of our race may be enlightened and encouraged in their work for humanity, therefore be it further resolved that we, as Afro-American women, accept these opportunities by entering this open door, and heartily endorse the work taken up by the W.C.T.U., but insist that their attitude in regard to the lynching evil and color-prejudice question generally be less equivocal.

* * *

Mrs. Matthews offered an amendment, and the resolution was adopted. The amendment was as follows:

Resolved, That this Congress recommend to the various organizations here represented, local, state and national, the wisdom of uniting for the establishment of one national organization of women.

WHEREAS, we as a race have never been taught to feel and appreciate the value of good homes and

WHEREAS, to this day there are to be seen in many of our

country communities the one room log cabin where many live together in an unwholesome atmosphere which is detrimental both morally and physically to the best growth and development of the masses,

Resolved, That as a body of women we do urge upon the teachers and leaders of our race the necessity and importance of mother's meetings, social purity talks and such other agencies as shall most forcibly impress upon the mothers of our race the evil influences generated by the admission of frivolous or obscene books or pictures into their homes.

WHEREAS, the colored women of this country stand very greatly in need of all the aid and assistance that the more fortunate and intelligent members of the race can offer them, and

WHEREAS, the elevation of the motherhood and womanhood of the race is the most effectual and powerful means for raising the mental and moral standard of the masses of our people, therefore be it

Resolved, That we hereby pledge ourselves individually and collectively to use every effort in our power,

1. To establish homes among our people the influence of which will tend to the development of men and women of strong character and purity of purpose in life.

2. To demand of our leaders and teachers the highest standard of character, refinement and culture.

3. That we require the same standard of morality for men as for women, and that the mothers teach their sons social purity as well as their daughters.

4. We condem the universal prodigality of the race and urge upon our people, having the best interests of the race at heart, to give permanence to our present progressiveness by practising strict economy in their homes and business relations, and to count no effort insignificant which is made in the interest or with a view toward the purchase of a home.

Resolved, That it is the duty of the colored women of the country to take a more practical interest in the condition and treatment of the unfortunate members of our race and in making proper provision for

the establishment of reformatories and institutions for the orphans, the aged, and the infirm, not excepting those institutions that have steadily adhered to the broadest of philanthropic principles, and thrown wide their doors to suffering humanity regardless of color, past condition or creed.

Realizing the gravity of our social and economic condition, and the wide influences of our teachers in assisting in the formation of the character of our children,

Resolved, That we urge upon those in authority to exercise the greatest diligence in selecting trained, competent teachers, who are imbued with the love and true spirit of their work. Further we urge upon parents the necessity of co-operating with the teachers in all matters that pertain to the successful development of those intrusted to their care.

Resolved, That in order to secure healthful bodies in which to contain healthful minds and souls we do heartily encourage all teachers, parents and guardians to make physical culture a prominent feature in their training of our youth.

WHEREAS, since every race must possess intelligence, energy, industry and enterprise in order that it may rank among the great and powerful races of the world, and,

WHEREAS, we feel that the life and prosperity of the home depends largely upon its women who are entrusted with its making, therefore be it

Resolved, That we endorse and encourage every phase of higher and industrial education and urge all persons to take such training as will elevate and make the noblest types of woman and man, and thus fit themselves for the actual responsibilities of life.


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Document 19: Excerpts from Aaron M. Powell, "The President's Opening Address," in *The National Purity Congress, Its Papers, Addresses, Portraits* (New York: American Purity Alliance, 1896), pp. 1-7.

Introduction

In 1893, the New York Committee for the Suppression of Legalized Vice and the WCTU organized a National Purity Congress at the 1893 Chicago Columbian Exposition. (See "How Did African-American Women Define Their Citizenship at the Chicago World's Fair in 1893?" also on this website.) The success of that first congress led purity reformers to form a new national organization, the American Purity Alliance, and to convene another National Purity Congress in Baltimore in 1895. The congresses broadened the appeal and increased the popularity of purity reform, and made the social purity movement a mass movement.[15] Aaron Macy Powell, as president of the new national purity group, gave the Presidential Address, which emphasized the continuing importance in the larger purity program of campaigns to raise the age of consent.

NATIONAL PURITY CONGRESS

———————

THE FIRST SESSION.

———————

THE PRESIDENT'S OPENING ADDRESS.

———————

BY AARON M. POWELL, OF NEW YORK, PRESIDENT
AMERICAN PURITY ALLIANCE.

We meet on this occasion in the First National Purity Congress held under the auspices of the American Purity Alliance. Our objects in convening this Congress are, the repression of vice, the prevention of its regulation by the State, the better protection of the young, the rescue of the fallen, to extend the White Cross work among men, and to proclaim the law of Purity as equally binding upon men and women.

Purity is fundamental in its importance to the individual, to the

home and to the nation. There can be no true manhood, no true womanhood except as based upon the law of Purity. There can be no security for the home, there can be no home-life in its best sense, except as it is based upon the law of Purity. There can be no true prosperity, there can be no perpetuation of a nation except as its life is based upon the law of Purity. Impurity is destructive alike to the individual character, of the home, and of the nation. Of the need of such a Congress as is now assembled the prevalence and propagandism of impurity, as the present time, everywhere so conspicuous in our large centers of population, abundantly testifies.

In the Old World vice, in many countries, is regulated by the State; it is legalized as a trade; it is a shocking system of practical slavery for dependent women and girls who are made its victims. It gives rise to an unholy traffic in girlhood; it occasions untold degradation on the part of women; it is a standing menace to the home; it abridges the liberty of all women in those countries. The relations between our own country and the Old World are now so intimate, the steamers passing to and fro so quickly and constantly as an international ferriage, make it impossible for us in America to be indifferent to the social conditions which obtain in Europe. It is on this account of vital importance that we recognize the struggle which is now going forward under the auspices of the International Federation for the Abolition of State Regulation of Vice, that we do what we can to aid and encourage its work. Law itself is a great educator for good or for ill. When the State assumes to license and legalize vice it educates downward and debases the moral sentiments of its people by such legalization.

In America we do not have, nominally, State regulation of vice. We do have, most unfortunately, in all our larger cities, a great deal of tolerated vice. Here as in Europe dependent women and girls are greatly exposed to vicious influences. With extremely low, in many cases almost starvation wages, the women's extremity becomes the vicious man's opportunity.

* * *

In another direction also may be seen an urgent need for the Purity movement which this Congress represents. It is in the so called Age of Consent Laws in the different States. The age at which young girls are deemed capable of controlling property is the age of majority: prior to that time the State intervenes for their legal protection in

connection with their property interests. Not so with reference to their persons. In four States, Mississippi, North Carolina, South Carolina and Alabama the Age of Consent is fixed at the shocking low age of ten years. In four States, Kentucky, Virginia, Nevada and West Virginia, the age is fixed at twelve years. In three States, New Hampshire, Utah and Iowa, at thirteen years. In the State of Maryland, in Maine, in Vermont, in Indiana, in North Dakota, in Georgia, in Illinois and in California at fourteen years. In Nebraska and Texas the age limit is fifteen years. In New Jersey, in Massachusetts, in Michigan, Montana, South Dakota, Oregon, Rhode Island, Pennsylvania and the District of Columbia the age is sixteen years. In Florida seventeen years. In New York, Kansas, Wyoming and Colorado eighteen years. In Delaware the original statute pertaining to the crime of rape is still unrepealed fixing the age at seven years, but the last Legislature passed an amended act which, practically, is designed to extend legal protection in that State to young girls to the limit of eighteen years. These so called Age of Consent statutes discriminate against girlhood and in favor of immoral men. They are, for the most part, a disgrace to the several States of this Union. Public attention has been directed widely to the subject through the combined efforts of the American Purity Alliance and other Purity and White Cross organizations, and especially by the Women's Christian Temperance Unions, and the movement has latterly been powerfully reinforced by the *Arena* magazine, conducted by Mr. Flower[A], with the special aid in this direction of Mrs. Helen H. Gardener. But it should be made much more a matter of concern in those States wherein the age is still ten, twelve, thirteen, fourteen, fifteen and sixteen years. The figures which I quote are such as have been recently furnished me, officially, by the Secretaries of State in the several States. They may not be, as in some cases I have found they were not, strictly accurate, but for the most part they undoubtedly represent the present actual condition of the Age of Consent Laws of our country. It is a matter which women and high-minded men everywhere should take to heart and do all possible to secure a speedy reformation and amendment of these laws.

Another object which this Congress it is hoped will do much to promote is greatly needed rescue work among the victims of vice. Rescue work for women, rescue work among fallen men as well as fallen women. Some of the speakers who will address the Congress during its sessions are experts in this sphere of service, from whose experience it is hoped, shared here by others, a new impetus will be given in this sphere of greatly needed Christian activity.

But even more inportant is preventive educational purity work among the young, and the older, which shall, ultimately, make rescue work no longer a necessity. The White Cross movement, which is especially for men, will therefore it is hoped also receive an especial impetus from this Congress, and that the interest in it may become sitll more extended. Its object, as defined by its pledge, is to teach its adherents first, to treat all women with respect and endeavor to protect them from wrong and degradation; second, to endeavor to put down all indecent language and coarse jests; third, to maintain the law of Purity as equally binding upon men and women; fourth, to endeavor to spread these principles among younger companions; fifth, to use every possible means to fulfil the command, "Keep thyself pure." In the higher education of men is the best possible safeguard for womanhood and girlhood.

It is to be hoped that one outcome of this Congress will be an increased emphasis upon the necessity for one moral standard for both sexes. It is in the double standard, one for men and another for women which has so long obtained in the public mind, that the schemes for State and Municipal regulation and the licensing of vice, and the unjust and immoral Age of Consent Laws, have their chief root and strength. The message, "Blessed are the pure in heart for they shall see God," is addressed alike to men and to women. It is hoped and expected that this Congress will do much to awaken interest on the part of the now largely indifferent public to the importance of these fundamental truths.

  

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A. Benjamin O. Flower was a purity reformer who popularized the age-of-consent campaign in the *Arena* and who by the early 1890s had turned his attention to preventive aspects of social purity. He founded Unions for Practical Progress, an ultimately unsuccessful purity organization. See Pivar, *Purity Crusade*, pp. 186-87.

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Document 20: Excerpts from Rev. J. B. Welty, "The Need of the White Cross Work," in *The National Purity Congress, Its Papers, Addresses, Portraits* (New York: American Purity Alliance, 1896), pp. 240-49.

Introduction

The White Cross society, founded in England in the early 1880s to help young men practice sexual abstinence, quickly spread to the United States sponsored by American Episcopalians. White Cross was a relatively popular organization that rapidly grew after it emerged in the United States in 1886. The White Cross society advocated a single standard of morality and spiritualized the sexual relationship between husbands and wives. The WCTU adopted White Cross as one of its reforms and Frances Willard toured the nation speaking on its behalf. This article explained the importance of the White Cross society to WCTU social purity work. It emphasized the need to eliminate the double standard, a major driving force behind the age-of-consent campaign. The age-of-consent campaign fit into a larger purity program within the WCTU as well within the social purity programs of a broader range of reformers. After the National Purity Congress in 1895, where this address was given, White Cross membership increased dramatically.[16]

THE NEED OF WHITE CROSS WORK.

———————

BY REV. J.B. WELTY, SECRETARY OF THE WHITE CROSS BRANCH OF THE PURITY DEPARTMENT OF THE NATIONAL WOMAN'S CHRISTIAN TEMPERANCE UNION.

The object of the White Cross Branch of the Purity Department of the National W.C.T.U. is clearly defined in article second of the constitution, and is as follows:

"To elevate opinion respecting the nature and claims of morality.

"To maintain the law of purity as equally binding upon men and women.

"To protect women from wrong and degradation.

"To preserve the purity of society.

"To shield the young and weak from temptations to impurity.

"To advocate the highest standard of manhood and womanhood.

"To uphold in their integrity the institutions God has appointed for social relations."

Is there any need for special work along these lines?

There is; and there never was a time in the history of our country when such work was so much needed as now. This is evident from the following considerations:

* * *

2. That White Cross Work is needed is evident from the fact that the double standard of morality is still operative in society. It is well known how that law binds the obligations of purity loosely upon men, but tightly upon women; that it condones in men what it damns in women; that it tolerates the scarlet man but condemns to eternal infamy the scarlet woman. It has been described as

> "A common law by which the poor and weak
> Are trampled under foot of vicious men,
> And loathed forever after by the good."

That unwritten but everywhere present and tyrannous law is wrong, unjust and severely cruel to women. It makes them the hunted game of protected libertines. It is wrong to men for it is a species of license for them to commit nameless crimes against women. It is also a wrong to society for it is a breaking down of the law that God gave for social purity. For the man and for the woman it is written: "Thou shalt not commit adultery."

The double standard means leniency to guilty men, and when lust is treated with leniency virtue is treated with indifference. Tolerance to scarlet men means danger to women--to our sisters and to our daughters.

This invidious law is to be reprobated also because it excludes the guilty woman from an equal chance with the guilty man for

repentance and restoration. Before God they have an equal chance to repent and reform and they should have the same equal chance before men.

There must be a mighty campaign of annihilation against this hoary, unjust and wicked law. The cruelty, tyranny, injustice and wrong of it must be portrayed before the people until public opinion is changed and its repeal secured.

3. That there is need for such work as the White Cross proposes is evident from the fact that women do, in many ways, suffer wrong and degradation.

There is discrimination against women in legislation, in business, in commerce, in the trades, in the shops, in civil service, in many schools and colleges and everywhere in matters of work and wages.

Men still arrogate to themselves the legislative function, and this is the prime cause for all unjust and unequal discrimination against women. They that do not have equal rights and privileges in political matters must suffer wrong and submit to limitations in many other places and in many ways. Keep women from the ballot and you debar them from a thousand other rights and make the path of human progress an unequal one. Continue to exclude them from legislative halls and they will be just so long handicapped in every other department of political and industrial life. It is more that we dare expect of human nature that one sex can or will wisely, justly, impartially and fully legislate for the other sex. Men in the past and up to the present time in all their legislation in matters concerning the sexes, have uniformly discriminated against women and no doubt will continue to so discriminate as long as they are the sole law makers. "Because of the hardness of their hearts" it has been so. The best for each, for the men and for the women, for society also, and the State, can be reached only when women as well as men shall have a voice and vote in the making of the laws that govern either or both.

Reward in the matter of wages has ever been and is to-day a grievous wrong against women. Poverty is the enemy of virtue, and women in poverty are doubly tempted. But there will be, there can be, no correction of this crying injustice until women can vote and have their votes counted. There can be no uplift for mankind to the highest and best until womankind is fully emancipated. The sexes must rise together and at equal pace, and with equal political rights, or they shall

both flounder together and remain incomplete. Political emancipation, full, free, unhampered, is the only leverage that can raise women from social and industrial damnation. No class of people, not even mothers, wives and daughters, can, in this democratic America, be denied political freedom and not suffer wrong and degradation. It is clear the protection to women--to all women--can be secured only by giving them a part and a voice in making the laws that concern their honor and well-being.

4. The need of White Cross work is made imperative because of the ravages of licentiousness.

Of all the master vices that prey upon and curse American society, or any other for that matter, it is admitted by those in a position to know, that licentiousness is the greatest. It is, more than all others, universal, deep seated and most deadly. It is easily the darkest sin in all the catalogue of sin and shame.

We have evidence that licentiousness to-day, as never before, has assumed the proportions and methods of a trade. It has the form, phases, agencies and machinery of a great, complicated, ramifying business. Its agents travel everywhere; the telegraph and the United States mails transmit intelligence for it; and the railroads, express companies and ships at sea carry its vicious freight. Vile literature in papers, magazines, books and pictures, full of unspeakable abominations, abounds everywhere and is propagating ideas of social nastiness.

The stage, now popular in city and town and village, with its spectacular scenes of love and lust and managed by a hundred thousand men and women, mostly low, lewd and lawless, is vitiating the minds and hearts of thousands, until their sense of the pure and the impure is obliterated.

The saloon, that legal institution of infamy and tyranny, is firing the passions of men and sending them down the scarlet avenues that lead to chambering and wantonness.

We see also that efforts are being made in different places and in high places and even in legislative halls, and with alarming success, to establish professional prostitution in our cities under cover of law and under the control of police force. That means the traffic in and the sale of untold thousands of the young daughters of the people throughout

the land. The procurer and procurers already travel, even under the guise of honorable business and sometimes of piety, to hunt for "the precious life." Incredible thousands of our sisters and daughters are sold every decade like cattle in the tolerated shambles of lust. Oh, the fearful ravages of licentiousness! Monstrous, harrowing, and still on the increase! There are now two hundred and thirty thousand (230,000) fallen women in the United States, and that means at least eight times that many fallen men. To supply the demands of passion in men one hundred families must give up a daughter apiece every day in the round year. What a draft this is on homes! What sin and shame and misery and heartaches and remorse and cruelty and murder and death and damnation this means! Think of it! Estimate if you can the fearful cost of this scarlet commerce! And then remember that this unclean, abominable, merciless business is going on now, that it is ever enlarging, spreading, taking in more victims; and there is little or no effort being made to stop it. What if it goes on for another ten or twenty years with the same ratio of increase that has marked it in the last ten or twenty years? "What will the harvest be?"

5. Special effort in purity reform is forced upon us because of the inadequate instruction, or lack of instruction, by parents in their homes, teachers in the schools and pastors in the churches upon the subjects of personal chastity and social purity.

The reticence of parents in these matters is well known. Because of temerity, false modesty, inability, or ignorance of the need of it, they fail to instruct children and young people in positive knowledge concerning sexual relations and duties. For the most part, especially with the boys, their first lessons about sex and reproduction and motherhood and fatherhood are learned from corrupt playmates, unclean innuendo, vile literature, obscene pictures, vulgar stories and unfortunate personal experience. There are some things, some knowledge about ourselves, that must come by teaching, by explanation, by discipline. Important among these are the facts and duties indicated in the Seventh commandment of the Decalogue. Let alone, boys run to the bad and at an incredible early age become impure in thought and often in practice.

In the public schools there is almost a total neglect of all the facts that pertain to sexual functions, relations and duties. Physiology stops short of these most important things and the young are left to inference, or to unfortunate ways for learning what above all they need to know. If we are to believe the testimony of teachers of public

schools then we are persuaded that uncleanness and vileness and impurity, in word and in conduct, are fearfully prevalent in them. Dr. J. H. Kellogg gives an instance where a superintendent of city schools made a careful inquiry into the personal habits of four hundred boys between the ages of ten and eighteen, and found but seven in the entire number who claimed to be free from impure practices. Nor is there any guarantee that the matter is going to be corrected, for our school authorities make no manner of provision for instruction in the laws and principles of sexual relations, personal chastity and social purity.

Nor is the pulpit of our times, save in a very few exceptional cases, outspoken in warnings and instruction concerning chastity, the sins of licentiousness, social disorders and dangers and all unholy sexual associations. There are but few preachers that ever preach on the Seventh commandment of the Decalogue; or upon Christ's law of purity; or give an exposition upon his teachings concerning marriage and divorce. If they took up these subjects more frequently they would not so often be caught officiating at the marriages of unlawfully, that is unscripturally, divorced persons.

Ministers are or should be in a special sense the monitors of public morals and the guardians of children and women. Yet how few there are who speak out bold, clear and timely words of warning against the sins of the flesh; and how seldom are sermons preached exposing the wrongs that are perpetuated against womankind; and how silent the pulpits are concerning the legislative crimes in every State of the Union, whereby the sanctity of marriage is destroyed, divorce made easy and promiscuous prostitution encouraged. The simple, sad fact is that the ministers in the churches are not doing the purity work that is needed. They have entered upon an era of silence upon this subject. They do not teach their young men as they need to be taught by their religious guides; they do not boldly and pointedly rebuke the old men of unclean habits; and plain words of counsel are never spoken to the women of the churches. Strange, guilty, dangerous silence! The old preachers and prophets were not like dumb dogs upon these subjects, and the preachers now ought not to be dumb where and when there is needed line upon line, precept upon precept and warning upon warning. Oh, for men like Nathan, who went to guilty David and said, "Thou art the man;" like John the Baptist, who went to the licentious Herod and told him frankly that he was living with the wrong woman.

In all this I make no charge against the ministry; I simply state a fact--sad, universal, alarming fact.

Somebody should speak out; somebody should tell the truth about these matters. The work must be done and God will find people to do it. If the ministry will not take it up God will raise up men, messengers and workers, from the ranks of the democracy who will take it up.

The W.C.T.U. seeing the ravages of licentiousness, feeling the power of unholy and unjust laws, like that of the double standard, knowing the need of reform and painfully, regretfully conscious of the silence in the churches, have felt constrained to take up the work. They have added to their purity department the White Cross Branch. They bid God-speed to all who are in the same work and extend the hand of co-operation to all workers in this important reform.

6. There is yet one other evidence that White Cross work is needed that should be mentioned in this place. It is the fact of the indifference, false modesty, cowardice and ignorance among the best people of the land concerning the nature, extent, power, threat and actual mischief of licentiousness.

To-day, as of old, it must be said: "My people perish for lack of knowledge. They do not know as they ought to know their dangers and their duties. The great Apostle to the Gentiles, seeing the people in sin and in ignorance, went to them, "warning every man and teaching every man that he might present every man perfect in Christ Jesus." Warning and teaching are the two important things needed to-day in purity work. To be well taught is to be well warned. Information here is social salvation. "To be forewarned is to be forearmed." The people, and especially the young people and the young men, need the teaching and they need the warning, and for this the White Cross is here. It seeks to arouse such a noble, beautiful chivalry as will lead every man to treat every other man's mother as he wants his own mother treated; to treat every other man's wife as he wants his own wife treated; to treat every other man's sister as he wants his own sister treated; to treat every other man's daughter as he wants his own daughter treated.

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Document 21: Anna L. Ballard, *Danger to Our Girls* (Chicago: Woman's Temperance Publication Association, [circa 1900]).

Introduction

Age-of-consent campaigns in various states were relatively successful, and by 1900, the legal age of consent had been raised to eighteen in eight states, and in another fifteen states, the age had been raised to sixteen. Although in California and in many southern states the battle continued through the first two decades of the twentieth century, the focus of the purity movement shifted to preventive social reforms, rather than punitive legal ones.[17] The remaining several documents illustrate the changes taking place in the purity movement at this time which shifted the focus of reformers away from the campaign to raise the age of consent and toward education about sexuality.

The WCTU popularized the preventive reform of mothers' meetings to educate mothers on how to build character and instill pure values in their children. Although originally conceived as a way to educate poor women how to teach their daughters to avoid seduction and remain morally pure, the meetings became dominated by middle-class women. The belief of organizers of the mothers' meetings that mothers could collectively purify society through careful rearing of their children gave a new value and dignity to women's work within the home. The following pamphlet was published by the WCTU as part of its series of social purity leaflets for mothers' meetings.

Danger to Our Girls.

L. ANNA BALLARD, M.D.

> "The fountain cannot rise higher than its source." The weal of humanity rests so heavily upon womanhood, and its life depends so much upon the activities and integrity of woman, that we must guard well this spring of the life of our race. A pure and bright girlhood, a strong and noble womanhood, an intelligent and watchful motherhood--these are conditions that must be kept inviolate or we shall cut ourselves off from our birthright as "children of the king." Either we have never risen to our best estate in these conditions or we have

fallen from it. Dr. Elizabeth Blackwell[A], of London, says, "The failure of young women of any country to embody the beauty and strength of virtue is one of the most serious evils that can befall a state." We will not go over the history of the past to learn if we ever reached nearer the perfect woman than we do now; we will accept the simple fact that to day there are dangers surrounding the girls, and they are largely growing into womanhood robbed of their power in integrity, self-reliance, and reserve. We must try to learn what these dangers are, and try to overcome them, and place in their stead those wholesome influences about girlhood that shall help it to rise to the full tide of womanly energy. We are convinced that these dangers do not come as the natural outgrowth of civilization, and the expanding of the opportunities of womankind. Indeed, enlarged opportunities, an expanded life, should build up a larger character, should inspire greatness of soul. The outlook for womanhood to-day should help to hold it closer to the divine heart, and to the divine plan in the upbuilding of character.

Dr. Sarah Hackett Stevenson tells us that "the childhood of this generation is crying out 'Educate my mother.'" The childhood of the next generation will cry in a still louder voice, unless certain traits that are growing into the character of women to-day are uprooted, and better ones implanted. We have learned in the study of heredity, that any class of influences will in time develop a certain trait of character. This is a blessed guarantee to us that if we are diligent in setting in motion good influences, we may outstrip the evil and bridge over the dangerous places. "It is ours to do; the results are God's."

We little realize how much the circumstances under which the young girl comes into this life have to do in shaping her character; and we do not sufficiently consider the strong bent given an individual life during the period in which all its growth and all its impressions come from the mother. To illustrate: in the character of women we have often to deplore the frivolity, the extravagance, and the monstrosity in their dress. How much of these traits were formed in those first months of the young life, by the intense concentration of all the powers of the mother-heart and brain upon the intricacies and minutiae of an elaborate wardrobe? Not alone in houses of wealth, but among most well-to-do people, how often we find the mother more absorbed in the baby's outfit than in the qualities of heart and mind which she alone can give it! Let me charge you with the words of Frances E. Willard: "Put your wealth into the arteries, store it away in the brain cells and heart fibres of your children."

To reap the greatest good of our civilization, and to make the most of the vast opportunities offered, we need to get back to simplicity of tastes and habits. We can never do this by cultivating in the girls, either before birth or after, tastes for elaborate dress or surrounding, cravings for luxury and ease, by being intensely absorbed in them ourselves. We have too much of this restless, desponding craving that impresses the moral constitution with a lack of stability of character, instead of that sterling self-reliance that we need to help the intellect to perceive right from wrong. We should shun any influences that tend to dwarf or belittle mind, soul or body. As a general rule, "as the girl is, so will the woman be." Few are able to outgrow or grow above defect in the early training. It is a notable fact in the history of families as well as of nations, that it is during the "hard times," that the hardy characters are developed. Ease and luxury tend to effeminacy, and do not give us strength to "endure hardness as a good solider." Cannot the mother-heart be impressed that it is safer and easier to form character right than to reform it? Habit is a controlling force in human character. Vice or virtue, indolence or industry, self-reliance or dependence, are elements of character established both by hereditary impress and by individual conduct and training. Miss Peabody formulated this thought when she said, "We can learn goodness by being good." So industry and self-reliance become permanent traits of character by training the child in these virtues. Some one has said, "Habits are moulds into which the plastic spirits are run, shaping the character." Are mothers mindful of this when they always sew on the buttons and darn the little breaks in the stockings, while the daughter, it may be far in her teens, pours out her vitality, exhausting her nerve energy, weakening and dissipating her mental faculties over an exciting novel, or promenading the streets? There is no better way to make a neat housekeeper of a girl than to train her to keep her own room in a neat, orderly manner. When and where do mothers expect their girls to learn the minutiae of home making, if not in their girlhood and under the kindly instruction of the mother? It is becoming a far too general custom with mothers for very insufficient reasons to excuse the girls from any care of their clothing or rooms. Let us note some of the results of this lack of home training. In the first place, all our faculties are developed by exercise, and any failure in this development dwarfs our powers and limits our possibilities for usefulness. Secondly, a life of healthful exercise by directing the life forces to the development of the muscular system and the enlarging of the mind, represses the activity of the nervous forces, which control the emotional nature and thus prevents the premature activity of the sexual system. As a rule, boys and girls who live in the country mature later than those accustomed to the excitement of city

life. The early awakening of the emotional nature is in every way prejudicial to the well-being of the young. Such awakening is at the expense of the integrity of nerve and muscle which need these early years for their maturity, before the life forces are so prominently directed to other channels. Dr. Kellogg in "Plain Facts," says, "Whatever occasions premature sexual development also occasions premature decay."

A third serious result of bringing up girls to idleness and dependence is their failure to become good housekeepers and home makers. One of the most blighting spectacles, and one of the greatest perils to the home lies in the lack of preparation among girls for the home life. When order and thrift and economy are not known in the home, happiness and virtue will not long abide. In the words of that noble English woman, Frances Power Cobbe[B], "Till you lift womanhood itself, you will never arrest--nay, you will never importantly diminish the dreadful curse, the great sin of great cities." The salvation of man must come through woman. She must know her power to attract and to hold in every good way and work, and must know how to exercise it. Marrying for a home is not a motive that will inspire women to their best efforts or grandest virtues. We do not mean that no responsibility rests upon men for the purity of the home. Neither do we mean that fathers and mothers have not need to be more watchful of the boys and more helpful to them. But because the girls of to-day are the mothers of to-morrow, the dangers that touch them touch not them alone.

The fourth result of not training girls to be self reliant and helpful is the saddest of all. The uncertainties and changes of life make it just as needful that the daughter of the richest, as well as of the poorest, should know how to care for herself, and to what she can turn her hand to earn an honest living. A training that develops skill in labor of any class is a tower of strength to a girl before temptation. A lack of any industrial training is a direct leading-string to sin and crime. This statement is amply illustrated by this fact given by Frances E. Willard in her annual address at the National Convention at Minneapolis. She says, "Of eight hundred and seventy girls and women who were arrested and lodged in one police station, in one month, in Chicago, only one hundred and thirty of them could sew or do housework, and none of them had ever learned a trade."

Nothing, except the grace of God, has more power than industry and self-reliance to keep us true to ourselves in the midst of

temptation.

It is not enough to train girlhood in these strong and helpful virtues. There are yet other dangers in their pathway, which too often blast the fond hope of the mother heart in the lovely young womanhood, and narrow the usefulness of promising lives. Is there not something wrong when girls grow up with a lack of reserve and self respect? Time was when the bold, flashy, flirting girl was the exception upon whom other girls looked with a shudder, abashed and astonished. Is she the exception now? Is not the lack of a true knowledge of themselves and their high and holy mission the enemy that robs them of their reserve?

Motherhood is a precious word, and a precious relation: but it is overwhelming in its responsibility. To train the young life through innocence into virtue is a mission that not every mother has yet dreamed of as hers. Too much is expected of girls, as well as boys, without training. Parents seem to expect the young to, grow into virtue, somehow, without any guidance respecting the most important and mystical faculty of their organism. Ignorance of selfhood is a constant pitfall to youth. Ignorance of self and its faculties is not virtue. Virtue is a strong power. Self control must include knowledge of self also. The highest human faculty is that of sex in its mental and physical powers. It is the one most closely related to individual life, and to all social life. There is no faculty more subject to the will and the mind, and none in which there is so great need for intelligent control. Without the restraining and intelligent guidance of the will, this one faculty may so enslave the being as to dwarf all other powers, and make an imbecile of the brightest intellect, or turn the finest nature into a satanic character. This is not because this faculty is a low order of our being. It is a great and noble force, adding grace and beauty and strength to human character. It is ennobling or degrading as it is developed under control of reason and helpful influences, or as the individual follows, unguided, the bent of every sensation, naturally developed, or unnaturally stimulated. Should a child be left unguided, with the possibilities of such a power within it? Not only the individual but nations and races deteriorate that follow a low standard of morals. Nations have lost their greatness, in moral degradation, for lack of wise guidance in the individual sexual life. All greatness rests upon virtue; and the nature that is left to follow its own sensations, to find out its own knowledge of itself, will be more easily drawn into vice than virtue. "Moral development," says Dr. Blackwell, "must keep pace with the intellectual, or the race degenerates." Any influence that degrades sex

in the mind of a people degrades the moral standard of that people. The high character of this faculty renders neglect of the right training of the individual the more dangerous. It is a physiological fact, that every faculty naturally develops and matures in a certain order. That order is maintained by the growth of the organ through which the faculty finds expression. The individual will descend in the scale of being unless the order is preserved. Any deviation from it, any forcing, or stimulating of a faculty, not only weakens and blights it, but, by diverting nutrition, robs all other faculties of their full development in strength and completeness. Each new faculty or life force has a dormant or formative period, but its active growth is marked by certain series of sensations. The beginning of sexual activity is thus marked by a predominance of sensations and emotions which need controlling by a wise influence. In that guidance should be exhibited the influence of the parent. The young life should not be left to judge of its own sensations. It would be quite as rational to leave the infant to follow its own instincts in the selection of food, or in the adjustment of its relations with its fellow beings, as to leave the youth, untaught and uncontrolled, at the mercy of his sensations as the sexual faculty is developing. It is in the light of the experience of one generation, given to the one succeeding, that advancement is made in social life. Dr. Blackwell tells us that "it is not rigid laws, nor formal intrusion that is needed, but the formative power of loving insight and sympathy." The great privilege of the parents is to be the confidant and counselor of the child, to whom it may freely turn with all its questionings. With the sacredness of the maternal instinct upon her, the mother, with tender and reverent heart, may well be the agent for conveying such instruction to the young.

Do you ask, "If the mothers do not comprehend the high and noble character of sex, in its dual nature of mental and physical power, how shall they teach their children?" We can only answer, responsibility and penalty do not stop because of the ignorance of any who may stand in the line of that responsibility. The perils and dangers only deepen and multiply with every successive generation, until, in the terrible prevalence of vice and crime, the duty is seen and by *the power of the parent* the race is brought back to its high estate in self knowledge and self control. The knowledge of good and evil is in the world. If the mother, unthinking, or indifferent, or incompetent, fails to set the one before her child, there are influences that will freely give to it the other. Have we lost the thought that parentage means something more than the simple bringing of life into the world? Have we forgotten that the soul has little to be thankful for in the gift of life, unless the tiny bud of character is opened by true knowledge and right influences into

its full bloom and beauty?

The power and influence of woman have not reached their zenith, but are expanding with every decade as she sees her duty before her, and especially for her children she will reach to her utmost power. In the words of Dr. Blackwell, "To be wise, knowledge of truth is essential, and the adult woman, the center of home influences, must acquire correct knowledge of all subjects that concern family life. A woman is mother always, not only of the infant, but of the growing and grown man. The high influences which women are intended to infuse into sex makes the subject a holy one to the wise mother. She can approach in moments of sacred earnestness which wound no natural reserve, but excite a grateful reverence in the young mind." Through the dependent years the child looks to the mother for comfort, and explanation of all things. In this confidence may it not always be held? May not the affection of the mother hold the daughter from early seeking outside the home for expressions of love, that are more liable to stimulate to premature development the latent faculty? Can she not, while watching and guiding the physical growth, also direct in self-respecting habits? "The key of moral education is respect for the human body and its faculties." The intelligent mother is careful to guide in the intellectual training of the young; shall she not be quite as anxious about the unfolding of the emotional nature? I cannot refrain from again quoting to you the weighty words of another:[C] "An invaluable provision for the education in the principle of sex exists in the companionship of brothers and sisters. The familiar intercourse of boys and girls in the kindly presence of their elder is of very great advantage. The friendship and affection of these natural associates should be sedulously promoted by companionship in studies, in music, in out-door pursuits and amusements. There is peculiar value in the influence of sisters. It is a special mission of young women to make virtue lovely. To make brothers love virtue, to make all men love purity through its incarnation in virtuous daughters, is a grand work to accomplish. The necessity of cultivating mental purity and respect for the principles of sex, exists as strongly in relation to girls as to boys; and it is only by securing this mental purity that young women will unconsciously address themselves to the high, rather than to the lower instincts, of their male companions."

Does not the mother betray her daughter, and future generations as well, when she accepts a double standard of morals, and for material advantage consents to her union with a profligate or licentious man; or when she sends her into her new home, it may be with an

elaborate wardrobe, or richly endowed with material goods, but without counsel upon the responsibility concerning the new life and relationship, and without forecasting to her the duties of maternity?

Aye, the pathway of girls, as well as boys, is hedged with dangers from the cradle to the grave; and with the inherited tendencies entangling them it seems well nigh hopeless to think of holding them in the pathway of moral rectitude. But woman is coming to the rescue. She is beginning to realize her power, and is rising grandly to the new conception of the Divine plane of human life; and when the motherhood of the race takes a forward step, all humanity must follow, all social life must be elevated. There is hope and courage in the fact that woman is hanging out the signal lights, and stationing sentinels at the pitfalls; that the thoughts of a degraded womanhood no longer finds her indifferent, but rather with all her love and pity aroused, seeking to turn the wayward into straighter paths, and to keep the tender feet of the little ones away from the thorns and briars.

  

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A. Dr. Elizabeth Blackwell, the first woman in the U.S. to earn a medical degree, was prominent in the moral education movement of the late nineteenth century. Moral educationists viewed sexual morality as the key to innocence and morality, and they used Blackwell's book, *The Moral Education of the Young* (1879) as their guide. Blackwell accepted the Chair of Hygiene at the new London School of Medicine for Women in 1875. She spent the last decades of her life in Hastings, England, where she died in 1910.

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B. Frances Power Cobbe was born in Ireland in 1822 and died in 1904. She published *Essay on Intuitive Morals* in 1855. She was involved in many reform movements, including the British woman's movement. She argued that violence against women was linked to women's economic dependence on men. She extolled the virtues of remaining single, and lived with another woman, Mary Lloyd, for thirty-four years until Lloyd's death in 1896.

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C. A note here states the quote was taken from Elizabeth Blackwell, *The Moral Education of the Young*.

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Document 22: Stanley W. Finch, *The White Slave Traffic: Address Before the World's Purity Congress* (Washington: Government Printing Office, 1912).

Introduction

The following three documents address the changing views of female sexuality after the turn of the century. They show how these changing views contributed to a diminishing focus on the state age-of-consent campaigns, although many of these campaigns extended until 1920. Historian Mary Odem contends that while many commentators began to argue that prostitution was due to female depravity, other reformers remained convinced that prostitutes had been tricked into a life of infamy by "white slavers."[18] The following pamphlet argued that many girls of good reputation were kidnapped, raped, and then forced into entering brothels. Although this article is similar to others about white slavery that appeared ten to fifteen years earlier, it calls for federal legislation against slavery and involuntary servitude, rather than arguing that raising the legal age of consent would allow for white slavers to be prosecuted.

THE WHITE SLAVE TRAFFIC

Address by Stanley W. Finch, Chief of the Bureau of Investigation of the Department of Justice before World's Purity Congress, Louisville, Ky., May 7, 1912.

The white slave traffic! What is it? Whom and what does it involve? Is it possible to suppress it, and if so how?

It is a fact that there are now scattered throughout practically every section of the United States a vast number of men and women whose sole occupation consists in enticing, tricking, or coercing young women and girls into immoral lives and then either living directly off of their illicit earnings or transferring them for a consideration to others for a similar purpose. Their business methods have been so far developed and perfected that they seem to be able to ensnare almost any woman or girl whom they select for the purpose. The great majority consists of young women and girls who have either been led to such lives by deception and trickery or who have been driven to them by force and fraud. The cleverly-worded advertisement for help is perhaps one of the most insidious and effective instruments which is or can be used.

These traffickers are generally shrewd, careful observers of human nature, and they are quick to perceive and to single out girls who--while as yet honorable and virtuous--are inclined to be somewhat careless, and those who, through lack of or distaste for parental restraint, undertake to select their own companions, amusements, and occupations. Among such young women and girls the white slaver finds a limitless and fertile field for his awful trade. In this connection the theatre, the moving picture show, the cafe, the skating rink, and the dance hall,--while in themselves often useful and beneficial for education, entertainment, and exercise, become instruments which enable these conscienceless fiends to accomplish the downfall and eternal ruin of even the most innocent and virtuous of our young women and girls.

Only a few months ago a young country girl, twenty years of age, while attending a moving picture show in this very city, met a woman whom she thought to be a friend, and who offered to secure domestic employment for her in a distant southern city. The young girl, herself innocent of any wrong, and unsuspicious, accepted the offer and, using the railroad ticket furnished her by her false friend, went to the address given, and not until she was imprisoned in that house and forcibly overpowered and ravished in the infamous effort to reduce her to that most awful slavery did this pure, brave-hearted girl realize that this woman here in Louisville was but the tool of a set of fiends to whom adequate punishment can never be administered by any of the processes of modern law. Through a fortunate chain of circumstances this young girl escaped the dreadful pit which is devouring thousands of other girls all over our land, but the awful business remains, a crying disgrace to our great country. Among the many other cases shown by our records is one involving a girl seventeen years of age, of good character, who lived in one of the smaller cities on Lake Michigan. This girl, while employed as a telephone operator, attended a dance where she met a young man of good appearance and apparently of good character. This young man was, however, a procurer for a house of ill repute in one of our large cities and while accompanying this young girl along the country road to her home, he forcibly ravished and subsequently placed her in a house of ill fame. This young man is now serving a term of five years in the penitentiary. The girl was rescued from the life of shame and returned to her parents. In another instance a girl of sixteen, while spending the afternoon at a seaside resort of one of our largest cities, was approached by two white slave procurers, who exhibited bogus police badges and pretended to place her under arrest as a truant. Supposing that they were acting under proper authority she made no outcry, and accompanied them to a street car

going in the direction of her home. The facts as to the manner in which this girl was subsequently intimidated by these fiends, and, under threats of death, compelled to go with them to a room where she was ravished and subsequently placed on board a coastwise vessel and taken to a house of ill fame in another city and state, and there confined and compelled to receive foreigners and turn the earnings over to the master to whom she was sold by her captors, are almost unbelievable. However, these facts were clearly established in court during trial, as a result of which the defendants are now serving terms in the penitentiary. Another case which was recently prosecuted by our Bureau of Investigation involves a young girl who answered an advertisement which appeared in a leading paper in one of our largest Southern cities. Under a contract made pursuant to this advertisement this girl proceeded to a city in another Southern state for the purpose of complying with the terms of her contract of employment. She found, however, upon entering her place of employment, that, instead of being a respectable house, it was a house of ill fame. Upon attempting to leave the place, she was forcibly detained and every effort was made to induce her to practice prostitution. However, she refused to do so and finally, with the aid of one of the patrons of the place, she secured assistance and was thereby enabled to leave the place. The defendant in this case was promptly convicted and is now confined in the penitentiary.

In very many places procurers endeavor, through promise of marriage or by actually going through the form of marriage, to obtain control of young women and girls, and finally force them into immoral lives. A case of this kind recently arose in one of the larger cities of the Middle West. In that case a girl seventeen years of age, and of a good character became acquainted in an apparently unobjectionable manner with a man who, like many of his kind, appeared, on the surface, to be of good character. After a brief courtship they were duly married and left on a wedding trip to a neighboring city, where the husband, claiming that he had lost his money and was unable to secure a position, attempted to persuade the young wife to engage in prostitution. She refused and was cruelly beaten by him. Apparently, however, even then she did not appreciate the nature of the creature to which she was married, and she went with him to one of our largest Eastern cities. There again he attempted to force her to engage in immoral practices, and upon her refusal she was beaten by him, food was withheld for days, and finally, when she had reached the point of exhaustion and was thoroughly intimidated, she was forced by her husband to receive foreigners whom he brought to her. By this means

the girl was degraded to the point where her master was able to force her to solicit on the streets and finally she was transferred by her procurer, through a white slave agency in New York City, to a house of ill repute in the City of Washington, where she was when the facts as to the matter were developed by our Bureau. As a result of the prosecution in this case, the defendant was sentenced to five years in penitentiary at Atlanta, Georgia, where the manager of the agency through which she was sold is also confined. The girl was restored to her parents, and has since been living a respectable life. In another notorious case which occurred in one of our Southern cities, the defendant, who is now serving a term of three years in the Atlanta penitentiary, married a very a young girl--a mere child--and took her from place to place, arranging with cab drivers and keepers of assignation houses for meetings between his wife and other men, he taking the proceeds. The investigation in this case showed that he had previously married other girls and mistreated them in a similar manner. In another recent case which arose in one of our Eastern cities one of these white slavers, as a result of carefully laid plans, covering a considerable period, succeeded in separating a very young woman from her husband and under the pretext of procuring a divorce and of marrying her, led her into an immoral life and finally succeeded in compelling her to practice prostitution and turn over her earnings to him.

There are a multitude of other cases in which young women and girls, from thirteen years of age and upwards, of good moral character, have, in a variety of ways, been led or driven, by deception, fraud, and force, into becoming victims of the white slave trade.

If there is one thing above another which it seems to be difficult for people generally to understand, it is with regard to the manner in which these girls are led to continue in their immoral lives and to surrender their earnings to the white slavers *after the physical restraint, to which they are at first subjected, is removed*. In the first place it should be remembered that when these girls fall into the hands of procurers an attempt is made to debauch them; as speedily as possible, to such an extent that they themselves, as well as every one else, will feel that they are hopelessly lost and can never again be received by their families and friends, and that there is absolutely no chance for them to go back to their old modes of life. Many of these girls disappear in such a manner that their relatives and friends never know what has become of them. Their relatives some times fear the truth, but they hope against hope that they are mistaken, and when,

after a while, they receive from the girl a communication--written at the dictation of her master--to the effect that she is engaged in some legitimate occupation and is happily situated, they are only too ready to believe that such is the case, and the girl herself no doubt, takes comfort in the thought that her relatives and friends know nothing of the depths of degradation to which she has been driven. These circumstances serve the procurer well. He makes it his business to obtain full information as to the relatives and friends of the girl, and knowing the real facts as to her life, and knowing that she feels that it would be better to perish in that life than to bring shame upon her mother or father or her other relatives or friends, he uses this knowledge as a club to force her to do his bidding. If at any time he sees a disposition on her part to leave him and to return home or to engage in some legitimate occupation, he threatens to tell her mother and her friends all about her and to represent to them that she has voluntarily engaged in the nefarious business into which he himself has driven her.

These creatures also frequently represent to their poor slaves (whether truthfully or not it is not for me to say) that they "stand in" with the police authorities, and are able and ready at all times to protect them from arrest or to secure their release by furnishing bail or otherwise in case of arrest, provided they do their bidding. They also threaten to cause their arrest and imprisonment if these poor victims fail to do their bidding.

These representations and others, which readily occur to these unscrupulous traffickers, who hesitate at nothing in order to hold their victims, usually serve to induce girls to at least *postpone* the time when they will change their mode of living, and often enable these men to control them without physical restraint, other than an occasional beating, after they have had possession of them for a few months.

One of the principal representations that is made by these men to the girls, in order to continue to hold them under their control, is that they are saving the money for them in order that both, within a short time, may quit their improper mode of life and take up some legitimate line of business. The date when they are to take this step is, of course, put off from time to time, as necessity arises, in order to hold the services of the girl, and many false representations are made as to the manner in which the money is being saved, the whole purpose of the white slaver being to retain possession of the girl during the period of her greatest earning capacity and eventually to drop her or turn her

over to some other trafficker when he finds it to his advantage, and opportunity arises, to procure a younger or more attractive girl for his use. Meanwhile the traffickers themselves take practically all of the earnings of their girl or girls, as the case may be--except that portion which is appropriated by the madam of the house in which the girl is located--and spend it for flashy clothes and in gambling and drinking, they in some cases spending a portion of their time in soliciting trade for their slaves.

In most of our cities of any considerable size there are numerous restaurants and other places where these slavers congregate for the purpose of drinking, smoking and discussing their affairs. With them the girls are mere chattels, and are lightly spoken of by them as their "meal tickets" or their "stock," and deals are made between them for the exchange of girls or for the turning of them over to other traffickers. As for the girl herself, between the madam, who usually receives one half her earnings, and the men to whom she is generally required to turn over all of the rest, and by whom she is also held to a strict account and is frequently beaten and otherwise abused if her earnings are not sufficient to satisfy him, the poor girl is indeed in a miserable plight. No other form of slavery which has ever been devised can equal her condition.

Hours and days might well be consumed in explaining the facts and conditions involved by this white slave traffic in the different sections of the country, but if it has been made clear that *there is such a traffic, that it extends throughout our entire country*, and that it involves conditions which are a disgrace to our nation it would seem that little else need be said regarding this phase of the matter, unless it be to add that it is estimated that not less than 25,000 young women and girls are annually procured for this traffic and that no less that 50,000 men and women are engaged in procuring and living on the earnings of these women and girls, and that the number of women and girls engaged in prostitution in this country at the present time is estimated at not less than 250,000.

The white slave evil is one of a national character, which cannot be successfully dealt with by local authorities. This leads us to consider the facts as to the means available for its suppression. By the Constitution of the United States the Federal Government is given three i[m]portant powers which have a direct bearing upon this traffic[;]

(a) By Section 8 of Article I of the Constitution Congress is given

power "to regulate commerce with foreign nations and among the several states."

(b) By the same article and section it is given authority "to establish post offices and post roads."

(c) By Section 1 of the 13th Amendment to the Constitution it is provided that "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction," and by Section 2 of the same amendment it is provided that "Congress shall have power to enforce this article by appropriate legislation." It is believed that by these provisions sufficient authority has been vested in the Federal Government to enable it, by enacting and enforcing appropriate legislation, to absolutely wipe out every vestage of this awful traffic.

Having in mind its powers under the interstate commerce clause of the Constitution, Congress enacted, June 25, 1910, what is known as the White Slave Traffic Law, by which the transporting or the persuading, enticing or coercing of women and girls to travel in interstate or foreign commerce for the purpose of prostitution or for any other immoral purpose, is made a crime. It is of the highest importance that legislation be immediately enacted which will absolutely prohibit the use of the post office in procuring woman and girls (by advertisements or otherwise) and in directing their movements, not only from state to state, but *also from one place to another in the same state*, and in soliciting and receiving earnings from victims of white slavers.

With reference to the slavery clause of the Constitution, it will perhaps be somewhat surprising to learn that there is *no Federal law which makes it a crime for one person to hold another in slavery or involuntary servitude, unless such person has been, in the first instance, kidnapped or carried away or bought or sold*; and although our investigations have, in numerous cases, developed the fact that young women and girls have been actually deprived of their liberty and held in involuntary servitude of the vilest kind (they having had their street clothes taken away from them--in many cases having been confined by barred windows and locked doors, and also having been deprived of their liberty by drugs, threats of violence, and by actual personal violence) there seems to be no statute under which persons so holding them in slavery can be punished by the Federal

Government. It is believed that under the circumstances a most rigid law should be enacted under this clause of the Constitution.

There are a number of other matters which it might also be well to cover in order to fully provide for the suppression of the white slave traffic.

1. There should be an act of Congress authorizing a woman to testify in such case against her husband. This is particularly essential for the reason that, as has already been stated, it is a common practice for procurers to marry their intended victims, and it is frequently impossible to secure a conviction without the use of the testimony of the woman or girl involved.

2. Provision should be made by law for the issuance of search warrants by any United States court or United States commissioner or justice of the peace or other similar official on behalf of the United States, such warrants to authorize United States marshals and deputy marshals, and agents of the Department of Justice specially designated by the Attorney General for the purpose, to search any place where there is probable cause to believe that any person is detained or held in violation of law.

3. The law should also authorize the arrest, without warrant, by the persons heretofore mentioned, of any one detected in the act of violating any such statute.

4. In order to assure prompt trials and substantial, swift and certain punishment in such cases, the law should also provide for the advancement of such cases, and their trial without delay, upon request of the Attorney General. It should also fix, with exactness the minimum penalty in such cases and require judges to promptly impose and cause the execution of sentences and prohibit the suspension of sentences by the courts.

While it was believed that steps should be taken for the absolute suppression of the white slave traffic, in so far as it was possible to do so under existing law, and while it was felt that the circumstances justified the appropriation of a very substantial sum for the purpose, in order to avoid the appearance of extravagance, and since it was thought that a comparatively small sum might be quickly secured, whereas there might be considerable delay if a large appropriation were requested, the Attorney General called upon Congress for an

appropriation of $25,000 for the purpose of defraying such expenses for the remainder of the fiscal year, ending June 30, 1912, and also requested that his general appropriation for detection and prosecution of crimes for the fiscal year, ending June 30, 1913, be increased in the sum of $50,000 over the appropriation for the present fiscal year in order to provide funds for work in white slave cases during the coming year. The urgency of this matter has been called to the attention of the proper government officials and committees of Congress both by the Attorney General and by individuals and philanthropic societies in almost every part of the country, all of whom have urged the immediate appropriation of adequate funds for this purpose. While--perhaps through some misunderstanding as to the real situation--there has been an unfortunate delay in securing additional funds, and consequently the work of the Department in attempting to suppress the white slave traffic has been temporarily crippled, I am glad to be able to say that we now have reason to believe that Congress will in due season appropriate the full amount which the Department has requested for this purpose for the coming fiscal year, and that there is also a disposition on the part of Members of Congress, with but few, if any, exceptions, to provide whatever additional funds may be necessary to expunge this disgraceful blot of white slavery from the map of our beloved country, and to enable our country to take a stand before the nations of the world which will, at no very distant day, result in sweeping this monstrous evil from the face of the earth.

It is believed that when the people of this country begin to appreciate the enormous extent and the terrible nature of this great evil, there will be no disposition on their part to temporize with it, but that they will demand not only that funds be appropriated sufficient to adequately enforce the present law, but also that the law be so extended and strengthened that it will [e]nable the Federal Government to wipe out this evil for all time.

This leaflet supplied at 35c. per 100, prepaid by the International Reform Bureau, 206 Pa. Av., S.E. Washington, D.C. $2.00 per 1000, collect. Y.W.C.A. and other societies for safeguarding women and girls should distribute it widely.

Document 23: Robert A. Woods and Albert J. Kennedy, "The Morality of Sex," chapter 7 in *Young Working Girls: A Summary of Evidence From Two Thousand Social Workers* (Boston: Houghton Mifflin, 1913), pp. 84-100.

Introduction

The following chapter from *Young Working Girls* was similar to earlier purity literature in its view that it was young working girls who were in danger of succumbing to sexual advances. However, this work did not blame the male seducer, but rather blamed the conditions of life in the tenements, adolescent peer culture, and family life for loosening sexual standards among the working class. Rather than advocating raising the legal age of consent to protect these girls, the authors argued that girls needed to be morally prepared for the sexual temptations of adolescence through instruction in public school, Sunday school, in the settlement house, and in the home. By the 1910s, the focus had shifted away from punishment of the male seducer and toward reforming the sexually-experimenting adolescent girl.

CHAPTER VII

THE MORALITY OF SEX

Lowering of standards.

OPINION is practically unanimous that for some years there has been a gradual though appreciable tendency toward deterioration in moral tone among a great proportion of adolescent girls in tenement districts. This condition is attributed partly to the general laxity of the age, partly to immigration, and partly to the breakdown of family and neighborhood life. Many young girls fall into immorality because they are unhappy at home, out of sympathy with the other members of the family, hungry for affection, and without any direct outlet for their emotional energies. This unsatisfied inner life, combined with low personal and community standards, leads them into danger. A few morally contaminated girls set an example which spreads and affects a majority of the young life

of the neighborhood; as where a physician in one of the large cities stated that he had taken care of most of the mothers in his locality, not one of whom was immoral; but their daughters were largely so.

There is ground for belief that a large number of girls are morally lax. Very frequently a young woman will carry on illicit relations over a considerable period with a man to whom she is devoted and emerge without catastrophe. "A girl can have many friends," explained one of them, "but when she gets a ‘steady,’ there’s only one way to have him and to keep him; I mean to keep him long." It is again the common opinion that there is a large number of adolescent girls who involve themselves in immoral relations more or less indiscriminately, believing that if they do not accept money they keep themselves without the sphere of prostitution. Failing to realize the consequences, many girls in this class sacrifice themselves for a good time, or for presents in the shape of jewelry and clothing. The tendency in this direction is indicated in certain cities by the increasing number of girls from department stores and factories who are treated for venereal diseases in the various dispensaries and hospitals.

Moral lapse is increasingly understood to refer, not to the breaking of the law, but to discovery, and the penalty of lapse is interpreted as misfortune rather than the result of sin. The girl who lapses takes an attitude varying from feigned nonchalance to the deepest shame, which is, however, often chiefly distress over the ostracism involved. And it is the universal experience that the girl who falls finds it almost impossible to regain her self-respect in communities where she is known. While there is need, in tenement neighborhoods, of the wiser experience of to-day in such cases, concern may well be felt over a gathering undercurrent of sentiment that the girl can count on escaping the larger measure of disgrace if the father of her child marries her.

Public sentiment among girls toward lapse.

At present the sentiment of the average girl toward instances of moral lapse is constantly less censorious. When brought face to face with the practical thing itself in the case of a friend or acquaintance, the individual girl is likely to be ignorant and curious alike, spellbound, shocked, interested, and fascinated. Criticism takes the form of the sneers; is rather conventional than sincere and deep-seated; and is not always unmixed with a certain

degree of admiration for the success with the other sex which the difficulty implies. Most girls have at best a vague sense of the bearing of lapse on the future, and it is generally felt to be almost impossible to place the matter in such a light that the average girl will recognize the harm created by moral wrong, except through some actual observation of its bitter results.

Sentiment of the home toward lapse.

The home, too, often fails in its proper moral reaction toward these tragedies. In some homes there is only indifference, provided marriage is the outcome; in others there may be extreme intolerance. There is more often family self-pity than any realization of the failure of the family group itself which such a lapse implies. In most cases the neighborhood attitude is one of mild revulsion toward the man and greater recoil from the woman. It is neither as indifferent on the one hand, nor as indignant on the other, as the family.

Evil beginnings previous to adolescence

Without exception it is believed that the girl who becomes morally lax has been influenced in that direction before she enters upon the age period under consideration; if not physically, at least in thought. Familiarity with degrading sights and unclean language often affects her character to such an extent that she does not comprehend the significance of her new feelings and desires, and goes astray almost without volition. Children are led into evil by their companions and by older young people, as well as by many forms of suggestion. The seeds of contamination are sown on the streets and in the alleys; in certain candy and other small stores in city neighborhoods, whose vicious proprietors teach some of the worst forms of immorality; in the day schools, and especially in the Sunday Schools; in the very homes of the children. The community has so far failed to take account of the number of sexual perverts at large, and the serious fact that every such individual is likely to be an extremely active center of practically continuous contamination. Though all these influences affect the innocent-minded yet moral lapse is very seldom to be traced to lack of knowledge of the risks and consequences of evil. The underlying cause is lack of ideals; the ignorance and carelessness of the families and neighborhood; the failure of parents to live up to their obvious duty.

Moral preparation for this period: (1) the schools;

The girl is in no way prepared intelligently to face the moral dangers which arise in adolescence by the instruction given in the public school. There are a few exceptions to the baldness of this statement, as in the case of children who have been influenced by an exceptional teacher. Yet even those who cite exception admit that the school must be radically changed before it will be able to exert real moral influence. Its equipment and instruction must be strengthened at many points. Among next steps to be taken are the installation of decent toilets; the supervision of basements; more home and school visitors with nurse's training, to give their time to developing a basis of understanding between parent and child; a very much higher grade of teacher; a sound experimental approach to the problem of instruction in matters of sex; the development of a corps of special leaders to take charge of such instruction in the grammar schools; a regular course of studies planned about natural history, hygiene, physiology, science, and home-making; and the multiplication of carefully supervised but democratically organized group activities outside of school hours among boys and girls.

(2) the church;

It is the universal sentiment of the contributors to this study that comparatively few girls come under adequate and forceful religious leadership. The Catholic religious organizations make an attempt at sex instruction, although such teaching is in general far from wisely given. Occasionally a leader arises from among the members of a teaching order, or even among the laity, who is wonderfully influential; but these stand out as exceptions. Even more, the sects of Protestantism, considering their resources, have failed to affect girls as they should. Of late years the Jewish religious authorities have become much concerned about moral declension among their young people and are striving to develop more effective forms of moral influence. It is undoubtedly true that the relative decay of religion is in itself one very serious cause of moral breakdown; and there is immediate and pressing need of more vital religious teaching on these fundamental questions of character.

(3) the settlement;

Settlements, too, have been lacking in the degree of attention given to specific ethical teaching. This

is partly because, to a very great extent, settlement workers belong to forms of faith alien to those of the neighborhood constituency. It is increasingly felt, however, that a sufficient basis of understanding has been reached to permit settlements to enter the field of practical morals without danger of misconstruction of motive. Instruction, however, should be carried on, wherever possible, in cooperation with the religious leaders of the neighborhood; the traditions of the local church should be kept in mind; its particular shade of moral emphasis should be enforced; interest should be developed in its traditions and faith; and every opportunity taken to strengthen those particular moral idealisms which are native to the people.

(4) the home.

The most telling cause of immorality is to be found in comparative disintegration of the home. In a sense it is encouraging that the large majority of these moral tragedies can be traced to some serious structural disorganization of the family. It is true, however, that a surprisingly small proportion of homes exert positive and constructively sympathetic support in helping the girl maintain her moral standards. In certain cases the support is positive without being sympathetic, the home standing emphatically for virtue and righteousness, though it does not discerningly safeguard the girl. Even where the moral sense of the family is real, if it is not sufficiently reinforced by a vital religious faith, it may prove quite ineffectual as against the facts of city life.

Value of instruction in sex hygiene.

The helpfulness of instruction in sex hygiene depends chiefly on the instructor. At present the average working girl "knows everything the wrong way," and only instruction based on scientific knowledge can correct this. The subject-matter of instruction should not be predominantly physical, but rather ethical and spiritual; and direct sex instruction should make up the smallest part of the teaching. The definite problem is that of building up a sound coherent attitude toward life and human nature; of lessening the stress and hardship of living, so that boys and girls can realize the best that is in them; of demonstrating what it is that makes a true home; of awakening loyalty to the present and the future self, to the home, and to the neighborhood. Instruction should be spread out over a considerable time rather than compressed into one or two talks. There is great advantage in beginning with young children before the age of sex

consciousness. Instruction can succeed in the end only as every one -- and especially parents, teachers, and religious leaders -- becomes awake to its necessity and significance.

It is generally agreed that mothers should be induced to discuss with their daughters questions of sex hygiene and sex relations, the responsibilities of motherhood, and the value of home life. Many mothers, however, believe that their daughters know nothing about such subjects and prefer that it should be so; others are frankly afraid to treat the matter; others feel that they have no vocabulary for the explanation. To meet these two latter situations certain settlements have organized talks before the women's clubs, and in a few instances have collected a small library, the books of which are loaned to mothers. Though the task of inducing mothers to give such instruction is beset with difficulty, it is indicative of the distinctively settlement method of meeting responsibility by helping its proper bearer to carry it; a course which is, under present conditions, infinitely harder though in the end much more rewarding than the opposite one of imparting instruction directly. It is interesting and significant that in one city the school authorities maintain classes to teach mothers how to instruct their adolescent children.

Where the mothers cannot be induced to give the necessary instruction, most settlements set about securing the parents' permission to present the matter to their daughters. This is done through explanations before the women's clubs, and by calling on individual mothers and explaining clearly and frankly the dangers of ignorance. There is always a proportion of women who are certain that any instruction is unwise; but the majority are glad to be relieved of responsibility by which they are more or less consciously worried.

The best opinion is in favor of individual instruction for adolescent girls, though before adolescence instruction may well be given in groups. Where the individual approach is not practicable, which is the common condition, the group should be kept small; six being the number most mentioned. As far as may be, the members of the class should be a club group, of like age and experience. Wherever possible the subject should be introduced incidentally. General discussion should follow the talk, and future individual conferences should be systematically encouraged. In a few instances books are lent after a talk to girls who desire them. There are very exceptional instances in which a measure of success is attained with large groups. In such a case it should be deliberately planned to include not less than twenty-

five in the group, in order that the individual may be lost in the whole. It is universally agreed, however, that it takes a genius to get results in this way.

Interests which strengthen character.

There are several leading motives to which intelligent social workers appeal in promoting practical morality. Everything possible should be done to ennoble the relations between the sexes; to purify the tradition concerning romance through the spread of the great novels; to eliminate cheap kissing games, cheap plays, and low dances; to create a love of fine things in the home, in literature, and in life generally; to multiply opportunities wherein young people themselves assume the responsibility of planning recreation, conducting negotiations, expressing ideas for groups, and holding office. Many adolescent girls are greatly strengthened by being helped to the acquisition of some characteristic skill or power, especially where it leads to advancement in their work. Certain are fortified through encouragement to save, to work against special odds, or to meet new and trying situations. Participation in a good home and early religious training, especially where religion is interpreted in terms of responsibility to others, are safeguards of a constructive sort. There is a strong feeling that membership in trade unions and in organizations for the promotion of woman suffrage is a vital source of character growth to working girls. But the most often mentioned source of moral power is capacity for leadership. The girl who excels in athletics, dancing, dramatics, skating, music, intellectual interests, home-making, or even in the artistic side of dress, apparently has a superiority over the average girl which goes far toward compelling a general standard above that which she finds about her.

The net result of experience with working girls is that they have remarkable capacity of moral resistance. On the whole the discerning social worker is constantly moved by the knowledge of their instinctive rectitude. The most serious meaning of this chapter is not that a great proportion of girls are unchaste, but that of all those who escape that fate practically every one has her whole moral nature grilled, harrowed, and distraught, by tests and strains that are well-nigh overwhelming in their intensity and persistence.

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Document 24: Louise de Koven Bowen, "Legal Protection in Industry," chapter 3 in *Safeguards for City Youth at Work and at Play* (New York: Macmillan, 1914), pp. 52-53, 58-59, 92-93.

Introduction

By 1914, many reformers believed that a major cause of the moral downfall of working women was low wages, which among other problems led girls to depend on male treating to enable them take part in leisure activities to break up the monotony of long hours in the workplace.[19] This author suggested legislation to set a minimum wage as well as maximum hours for women workers would help them to resist sexual temptation. This article illustrates how the focus had shifted from blaming male seducers to reforming the circumstances of working-class women.

CHAPTER III

LEGAL PROTECTION IN INDUSTRY

THE attention of the Association was first called to the moral conditions in the department stores through the complaints of the dangers found in the waiting rooms, especially to out-of work girls who were prone to gather there. An investigation disclosed large numbers of young girls in the waiting rooms of the State Street stores who came every day to read the morning papers and look for "Want" advertisements. After they went out to answer these "Want ads" in the morning papers, they would come back again at noon to read the afternoon papers, thus spending most of the day there. We found that many men and women went to these waiting rooms for evil purposes. They would get into conversation with the girls by offering a newspaper or other small courtesy and sometimes they would extend an invitation to luncheon. One young Hungarian girl who went out to luncheon with a young man the first time she met him in one of these waiting rooms was rescued from a disreputable house a month later.

In three weeks' time our officer who made this investigation arrested and convicted 17 men and 3 women who were plying their trade in department store waiting rooms. The Association conferred

with the managers of all stores who were of course most anxious to cooperate and stop this practice. They adopted our recommendations in almost every instance, putting on more matrons of a type capable of exercising some kind of chaperonage. Through the effort of the Eleanor Association [a free] employment bureau for girls was afterwards opened downtown with large waiting rooms where the girls could sit and read the newspapers and through which situations could be obtained for them.

During this investigation of the waiting rooms, it was found that the girls regularly employed in the department store itself were surrounded by many dangers. At the time of the investigation, the ten hour law for women had not yet been passed in Illinois and the excessive fatigue induced by overwork, coupled with the minimum of time for leisure and recreation, often makes it difficult for girls to withstand the temptations which press hard upon them, and which lead to a moral as well as a physical breakdown. This is doubly true in the department stores where girls work surrounded by the luxuries which they all crave and where they receive a wage, inadequate for a life of decency and respectability.

* * *

Second, the girl is often at the mercy of the man who is recruiting for a disreputable house. He may purchase articles from her and make insulting remarks, while at the same time he makes up his mind as to whether he will be able to persuade her to enter an immoral life. It frequently happens that if a girl refuses to have any conversation with the man outside of business communication, he reports her as impertinent to the manager or floorwalker and many of the girls say that in a number of stores, as the result of such a charge, they are often dismissed without a chance to even give the other side of the story.

As an illustration of this second danger, a young girl employed at the ribbon counter in one of the department stores was accosted by a young man who purchased several yards of ribbon and then invited her to lunch with him, telling her that if she had a friend he would bring his chum and they would have a party of four. The girl, starved for pleasure and anxious for some excitement to relieve the monotony of her day, found a girl friend and they both accepted the invitation. The girls lunched with the young men several times a week for three months, and they were also invited out to dinner; finally, one night the

two couples became separated and the girls, who had drunk too much wine, found themselves later on ruined and deserted.

* * *

The courts in the United States are rapidly sustaining legislation for the protection of women. Within thirty days during February and March of this current year, the Supreme Court of Oregon by a unanimous decision sustained the minimum wage law; the Supreme Court of the United States in an Ohio case sustained the 54-hour week, the 10-hour day and the 6-day week, and by the vote of Congress 8 hours for women workers was established in the District of Columbia.

It would seem as if the first duty of society were to protect the ever increasing throng of working women who are entering the industrial world by demanding for them a shorter working day and an adequate wage and by giving them ample opportunities for recreation. Only when we guard working girls from industrial overstrain and from dullness during their leisure hours, will they be able to resist temptation and to properly fulfil the functions which belong to them. When minimum wage boards are established in every state it may be made clear to the community that the economic status may be responsible for the moral and physical dangers to which overworked, underfed and underpaid girls are subjected.

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Endnotes

Introduction

1. David J. Pivar, *Purity Crusade: Sexual Morality and Social Control, 1868-1900* (Westport, Conn.: Greenwood Press, 1973), pp. 103-10.
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2. For more on the American Female Moral Reform Society, see "What Was the Appeal of Moral Reform to Antebellum Northern Women?" also on this website.
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3. Mary E. Odem, *Delinquent Daughters: Protecting and Policing Adolescent Female Sexuality in the United States, 1885-1920* (Chapel Hill: University of North Carolina Press, 1995), pp. 8-9.
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4. Odem, *Delinquent Daughters*, p. 10; Pivar, *Purity Crusade*, pp. 83-88.
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5. Odem, *Delinquent Daughters*, p. 15; Pivar, *Purity Crusade*, pp. 140, 145.
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6. Odem, *Delinquent Daughters*, pp. 35-36.
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7. Pivar, *Purity Crusade*, pp. 107-08.

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8. Odem, *Delinquent Daughters*, p. 20.
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9. Pivar, *Purity Crusade*, pp. 132-37; Odem, *Delinquent Daughters*, pp. 11-13.
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Document 9

10. Odem, *Delinquent Daughters*, pp. 8-9.
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Document 11

11. Pivar, *Purity Crusade*, p. 152.
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Document 12

12. Odem, *Delinquent Daughters*, p. 18.
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Document 15

13. Odem, *Delinquent Daughters*, p. 34; Pivar, *Purity Crusade*, p. 145.
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14. Historian Mary Odem found only one Black Woman's Club that supported the age-of-consent campaign. Odem, *Delinquent Daughters*, p. 28. See "The Woman's Club of Omaha," *Woman's Era*, 2 (August 1895), p. 7: "In all reformatory efforts affecting mankind generally and women particularly the club enters enthusiastically. At the last general assembly of the state of Nebraska it was engaged earnestly in the effort to stop the manufacture and sale of cigarettes in the state, and joined heart and soul in the social purity question, sending down to the legislature a petition, bearing the names of 150 colored women, praying that body to raise the 'age of consent' from 15 to 18 years."
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15. Pivar, *Purity Crusade*, pp. 186-90.
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16. Pivar, *Purity Crusade*, pp. 110-17, 189.
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Document 21

17. Odem, *Delinquent Daughters*, pp. 36-37.
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Document 22

18. Odem, *Delinquent Daughters*, p. 97.
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Document 24

19. For more on the connection between the practice of "treating" and female immorality, see Kathy Peiss, *Cheap Amusements: Working Women and Leisure in Turn-of-the-Century New York* (Philadelphia: Temple University Press, 1986), pp. 53-55, 108-13.
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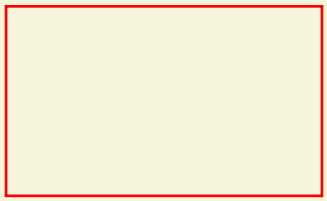

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Related Links

Helen Hamilton Gardener

Biographical sketch of Helen Hamilton Gardener (1853-1925), writer and suffragist who published two important novels for the social purity compaign, *Is This Your Son, My Lord?* and *Pray You Sir, Whose Daughter?* as well as other articles on the age-of-consent campaign.

Josephine Butler

Biographical sketch of Josephine Butler, leader of the successful fight to repeal the Contagious Diseases Acts in Britain, which effectively legalized prostitution. American reformers in the social purity movement greatly admired her work.

Woman's Christian Temperance Union

The official site of the Woman's Christian Temperance Union. The site includes information about the history of the organization, news and current events.

Pall Mall Gazette

An account of William Stead and the *Pall Mall Gazette*, and the publication's role in raising the age of consent in Britain.

"Reading Aright": White Slavery, Black Referents, and the Strategy of Histotextuality in *Iola Leroy*

This paper appeared in the Fall 1997 *Yale Journal of Criticism*. It connects the goals of the New England Female Moral Reform Society

with the argument of many African Americans at the end of the nineteenth century that powerful white men acted as the destroyers of the virtue of African-American women. The author argues that African-American women hoped that the shared analysis of male power would help them align with white women activists.

Victorian Women Writers Project Library

This site provides transcriptions of articles, pamphlets, poems, plays and books by women authors in Victorian Britain, including Josephine Butler. Butler wrote several books and articles that American social purity reformers were familiar with. Among them were: *Mrs. Butler's Appeal to the Women of America* (1888); *The New Godiva: A Dialogue* (1888); *Social Purity* (1879); and *Some Thoughts on the Present Aspect of the Crusade Against the State Regulation of Vice* (1874).

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THE CAMPAIGN TO RAISE THE AGE OF CONSENT, 1885-1914

Introduction

In the late nineteenth century,"Age of consent" referred to the legal age at which a girl could consent to sexual relations. Men who engaged in sexual relations with girls who had not reached the age of consent could be criminally prosecuted. American reformers were shocked to discover that the laws of most states set the age of consent at the age of ten or twelve, and in one state, Delaware, the age of consent was only seven. Women reformers and advocates of social purity initiated a campaign in 1885 to petition legislators to raise the legal age of consent to at least sixteen, although their ultimate goal was to raise the age to eighteen. The campaign was eventually quite successful; by 1920, almost all states had raised the age of consent to sixteen or eighteen.

Objectives

To understand the class, gender, and racial tensions within the age-of-consent campaign of the late nineteenth century; to investigate the differences in the views of diverse supporters of the campaign; to understand the broad appeal of the campaign to many groups of women; to see how reformers' solutions to the problem of the sexual exploitation of wage-earning women changed over time.

Lesson Ideas

1 Begin by reading Aaron M. Powell, "The Moral Elevation of Girls," February 1886; and "Protection of Girlhood," October 1886. Why did reformers believe the age of consent needed to be raised? Who did these reformers hope to protect? What attitudes did the middle-class women who ran the working girls' clubs have about wage-earning women? How did they feel about women's sexuality?

2 Continue to explore women reformers' views toward the relationship between men and women by reading the English reformer Josephine E. Butler, "The Double Standard of Morality," October 1886. What was the "double standard?" How did Butler propose to eliminate the double standard? How did she propose to change the nature of the relationship between men and women? Why did she believe these changes were necessary?

3 Begin a deeper discussion of women's active involvement in the age-of-consent campaign by first reading Bessie V. Cushman, "Another Maiden Tribute," February 1887; and Petition from the Woman's Christian Temperance Union for the Protection of Women to Congress, May 1888. How did Cushman hope to use "Another Maiden Tribute" to arouse public sentiment? What did she propose as a solution to the vice camps? Why would public support be crucial to her solution? Why might the petition be an effective weapon in the fight to raise the age of consent? Why did women send it to Congress?

4 Investigate how reformers' approaches to the sexual victimization of wage-earning women changed over time by reading Louise De Koven Bowen, "Legal Protection in Industry," 1914. What did this author suggest to prevent working girls from engaging in illicit sexual relations? How were her suggestions in 1914 different from the solutions advocated by reformers 25 years earlier?

5 Short paper assignment:

> Read "The National Colored Woman's Congress," January 1896; and Frances E. Willard, "Social Purity Work for 1887," January 1887. In a 2-3 page paper, compare the resolutions of the National Colored Woman's Congress to the social purity activities of the WCTU. How were the activities of the two groups similar? How were they different? What could account for these differences?

6 Long paper assignment:

> Read "Seduction a Felony," September 1888; Helen Campbell, "Poverty and Vice," May 1890; Elizabeth Cady Stanton, "Preface," to *Pray You Sir, Whose Daughter?* 1892; Helen Campbell, "Why an Age of Consent?" April 1895; and Helen Hamilton Gardener, "A Battle for Sound Morality," August 1895. In a 5-7 page paper, compare and contrast the arguments various reformers used to support the age-of-consent campaign. Questions you might want to consider include: What do the authors view as the cause of vice? What solutions do they propose? How do the authors feel about the age-of-consent campaign? What do the authors view as the differences and/or similarities between men and women? How do the authors feel a higher age of consent will improve women's lives?

For Further Exploration:

To investigate earlier efforts to eradicate prostitution and predatory male sexual behavior, see "What Was the Appeal of Moral Reform to Antebellum Northern Women?" also on this website.

Explore further the influence of the writings of English reformer Josephine Butler on the American social purity movement by reading her works available online at the Victorian Women Writers Project.

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Evolution of a classification scale: medical evaluation of suspected child sexual abuse.

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This article presents a revision of a system for classifying examination findings, laboratory findings, and children's statements and behaviors as to their possible relationship to sexual abuse. The revisions are based on published research studies and current recommendations from the American Academy of Pediatrics Committee on Child Abuse and Neglect, and the American Professional Society on the Abuse of Children. Part 1 of the classification system lists genital and anal findings that can be considered normal or nonrelated to abuse, nonspecific for abuse, concerning for abuse, and clear evidence of blunt force or penetrating trauma. Under Part 2, the overall classification of the likelihood of abuse is broken into four categories: no evidence of abuse, possible abuse, probable abuse, and definite evidence of abuse or penetrating trauma. Cautions in the use of the classification system, as well as controversies concerning a few medical findings, are discussed.

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Sexually Transmitted Diseases Treatment Guidelines 2002

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CONTENTS

Sexually Transmitted Diseases Treatment Guidelines 2002

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Summary

These guidelines for the treatment of patients who have sexually transmitted diseases (STDs) were developed by the Centers for Disease Control and Prevention (CDC) after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on September 26–28, 2000. The information in this report updates the 1998 Guidelines for Treatment of Sexually Transmitted Diseases *(*MMWR *1998;47[No. RR-1]). Included in these updated guidelines are new alternative regimens for scabies, bacterial vaginosis, early syphilis, and granuloma inguinale; an expanded section on the diagnosis of genital herpes (including type-specific serologic tests); new recommendations for treatment of recurrent genital herpes among persons infected with human immunodeficiency virus (HIV); a revised approach to the management of victims of sexual assault; expanded regimens for the treatment of urethral meatal warts; and inclusion of hepatitis C as a sexually transmitted infection. In addition, these guidelines emphasize education and counseling for persons infected with human papillomavirus, clarify the diagnostic evaluation of congenital syphilis, and present information regarding the emergence of quinolone-resistant* Neisseria gonorrhoeae *and implications for treatment. Recommendations also are provided for vaccine-preventable STDs, including hepatitis A and hepatitis B.*

Introduction

Physicians and other health-care providers play a critical role in preventing and treating sexually transmitted diseases (STDs). These recommendations for the treatment of STDs are intended to assist with that effort. Although these guidelines emphasize treatment, prevention strategies and diagnostic recommendations also are discussed.

This report was produced through a multi-stage process. Beginning in 2000, CDC personnel and professionals knowledgeable in the field of STDs systematically reviewed literature (i.e., published abstracts and peer-reviewed journal articles) concerning each of the major STDs, focusing on information that had become available since publication of the *1998 Guidelines for Treatment of Sexually Transmitted Diseases* (*1*). Background papers were written and tables of evidence constructed summarizing the type of study (e.g., randomized controlled trial or case series), study population and setting, treatments or other interventions, outcome measures assessed, reported findings, and weaknesses and biases in study design and analysis. A draft document was developed on the basis of the reviews.

In September 2000, CDC staff members and invited consultants assembled in Atlanta for a 3-day meeting to present the key questions regarding STD treatment that emerged from the literature reviews and the information available to answer those questions. When relevant, the questions focused on four principal outcomes of STD therapy for each individual disease: a) microbiologic cure, b) alleviation of signs and symptoms, c) prevention of sequelae, and d) prevention of transmission. Cost-effectiveness and other advantages (e.g., single-dose formulations and directly observed therapy [DOT]) of specific regimens also were discussed. The consultants then assessed whether the questions identified were relevant, ranked them in order of priority, and attempted to arrive at answers using the available evidence. In addition, the consultants evaluated the quality of evidence supporting the answers on the basis of the number, type, and quality of the studies.

In several areas, the process diverged from that previously described. The sections concerning adolescents and hepatitis A, B, and C infections were developed by other CDC staff members knowledgeable in this field. The recommendations for STD screening during pregnancy were developed after CDC staff reviewed the published recommendations from other knowledgeable groups. The sections concerning early human immunodeficiency virus (HIV) infection are a compilation of recommendations developed by CDC staff members knowledgeable in the field of HIV infection. The sections on hepatitis B virus (HBV) (*2*) and hepatitis A virus (HAV) (*3*) infections are based on previously published recommendations of the Advisory Committee on Immunization Practices (ACIP).

The material in this report was prepared for publication by the National Center for HIV, STD, and TB Prevention, Harold W. Jaffe, M.D., Acting Director; and the Division of Sexually Transmitted Diseases Prevention, Harold W. Jaffe, M.D., Acting Director.

Throughout this report, the evidence used as the basis for specific recommendations is discussed briefly. More comprehensive, annotated discussions of such evidence will appear in background papers that will be published in a supplement issue of the journal *Clinical Infectious Diseases*. When more than one therapeutic regimen is recommended, the sequence is alphabetized unless the choices for therapy are prioritized based on efficacy, convenience, or cost. For STDs with more than one recommended regimen, almost all regimens have similar efficacy and similar rates of intolerance or toxicity unless otherwise specified.

These recommendations were developed in consultation with public- and private-sector professionals knowledgeable in the treatment of patients with STDs. They are applicable to various patient-care settings, including family planning clinics, private physicians' offices, managed care organizations, and other primary-care facilities. When using these guidelines, the disease prevalence and other characteristics of the medical practice setting should be considered. These recommendations should be regarded as a source of clinical guidance and not as standards or inflexible rules. These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in STD/HIV prevention.

Clinical Prevention Guidelines

The prevention and control of STDs is based on the following five major concepts: a) education and counseling of persons at risk on ways to adopt safer sexual behavior; b) identification of asymptomatically infected persons and of symptomatic persons unlikely to seek diagnostic and treatment services; c) effective diagnosis and treatment of infected persons; d) evaluation, treatment, and counseling of sex partners of persons who are infected with an STD; and e) preexposure vaccination of persons at risk for vaccine-preventable STDs. Although this report focuses mainly on the clinical aspects of STD control, primary prevention of STDs begins with changing the sexual behaviors that place persons at risk for infection. Moreover, because STD control activities reduce the likelihood of transmission to sex partners, treatment of infected persons constitutes primary prevention of spread within the community.

Clinicians have a unique opportunity to provide education and counseling to their patients. As part of the clinical interview, health-care providers can obtain sexual histories from their patients. Guidance in obtaining a sexual history is available in *Contraceptive Technology, 17th edition* (*4*).

Prevention Messages

Prevention messages should be tailored to the patient, with consideration given to the patient's specific risk factors for STDs. Messages should include a description of specific actions that the patient can take to avoid acquiring or transmitting STDs (e.g., abstinence from sexual activity if STD-related symptoms develop).

If risk factors are identified, providers should encourage patients to adopt safer sexual behaviors. Counseling skills (e.g., respect, compassion, and a nonjudgmental attitude) are essential to the effective delivery of prevention messages. Techniques that can be effective in facilitating rapport with the patient include using open-ended questions, using understandable language, and reassuring the patient that treatment will be provided regardless of circumstances unique to individual patients (including ability to pay, citizenship or immigration status, language spoken, or lifestyle).

Many patients seeking treatment or screening for STDs expect evaluation for all common STDs; all patients should be specifically informed if testing for a common STD (e.g., genital herpes and human papillomavirus [HPV]) is not performed.

Sexual Transmission

The most reliable way to avoid transmission of STDs is to abstain from sexual intercourse (i.e., oral, vaginal, or anal sex) or to be in a long-term, mutually monogamous relationship with an uninfected partner. Counseling that encourages abstinence from sexual intercourse is crucial for persons who are being treated for an STD or whose partners are undergoing treatment and for persons who wish to avoid the possible consequences of sexual intercourse (e.g., STD/HIV and unintended pregnancy). A more comprehensive discussion of abstinence and the range of sexual expression is available in *Contraceptive Technology, 17th edition* (*4*).

- Both partners should get tested for STDs, including HIV, before initiating sexual intercourse.
- If a person chooses to have sexual intercourse with a partner whose infection status is unknown or who is infected with HIV or another STD, a new condom should be used for each act of insertive intercourse.

Preexposure Vaccination

Preexposure vaccination is one of the most effective methods for preventing transmission of certain STDs. For example, because hepatitis B virus infection frequently is sexually transmitted, hepatitis B vaccination is recommended for all unvaccinated persons being evaluated for an STD. In addition, hepatitis A vaccine is currently licensed and is recommended for men who have sex with men (MSM) and illegal drug users

(both injection and non-injection). Vaccine trials for other STDs are being conducted, and additional vaccines may become available in the next several years.

Prevention Methods

Male Condoms

When used consistently and correctly, male latex condoms are effective in preventing the sexual transmission of HIV infection and can reduce the risk for other STDs (i.e., gonorrhea, chlamydia, and trichomonas). However, because condoms do not cover all exposed areas, they are likely to be more effective in preventing infections transmitted by fluids from mucosal surfaces (e.g., gonorrhea, chlamydia, trichomoniasis, and HIV) than in preventing those transmitted by skin-to-skin contact (e.g., herpes simplex virus [HSV], HPV, syphilis, and chancroid). Condoms are regulated as medical devices and are subject to random sampling and testing by the Food and Drug Administration (FDA). Each latex condom manufactured in the United States is tested electronically for holes before packaging. Rates of condom breakage during sexual intercourse and withdrawal are low in the United States (i.e., approximately two broken condoms per 100 condoms used). Condom failure usually results from inconsistent or incorrect use rather than condom breakage.

Male condoms made of materials other than latex are available in the United States. Although they have had higher breakage and slippage rates when compared with latex condoms, the pregnancy rates among women whose partners use these condoms are similar. Non-latex condoms (i.e., those made of polyurethane or other synthetic material) can be substituted for persons with latex allergy.

Patients should be advised that condoms must be used consistently and correctly to be highly effective in preventing STDs. Patients should be instructed in the correct use of condoms. The following recommendations ensure the proper use of male condoms.

- Use a new condom with each act of sexual intercourse (e.g., oral, vaginal, and anal).
- Carefully handle the condom to avoid damaging it with fingernails, teeth, or other sharp objects.
- Put the condom on after the penis is erect and before any genital contact with the partner.
- Use only water-based lubricants (e.g., K-Y Jelly™, Astroglide™, AquaLube™, and glycerin) with latex condoms. Oil-based lubricants (e.g., petroleum jelly, shortening, mineral oil, massage oils, body lotions, and cooking oil) can weaken latex.
- Ensure adequate lubrication during intercourse, possibly requiring the use of exogenous lubricants.
- Hold the condom firmly against the base of the penis during withdrawal, and withdraw while the penis is still erect to prevent slippage.

Female Condoms

Laboratory studies indicate that the female condom (Reality™), which consists of a lubricated polyurethane sheath with a ring on each end that is inserted into the vagina, is an effective mechanical barrier to viruses, including HIV (*5*). With the exception of one investigation of recurrent trichomoniasis, no clinical studies have been completed to evaluate the efficacy of female condoms in providing protection from STDs, including HIV. If used consistently and correctly, the female condom may substantially reduce the risk for STDs. When a male condom cannot be used properly, sex partners should consider using a female condom.

Vaginal Spermicides, Sponges, and Diaphragms

Recent evidence has indicated that vaginal spermicides containing nonoxynol-9 (N-9) are not effective in preventing cervical gonorrhea, chlamydia, or HIV infection (*6*). Thus, spermicides alone are not recommended for STD/HIV prevention. Frequent use of spermicides containing N-9 has been associated with genital lesions, which may be associated with an increased risk of HIV transmission. The vaginal contraceptive sponge appears to protect against cervical gonorrhea and chlamydia, but its use increases the risk for candidiasis. In case-control and cross-sectional studies, diaphragm use has been demonstrated to protect against cervical gonorrhea, chlamydia, and trichomoniasis; however, no cohort studies have been conducted (*7*). Neither vaginal sponges nor diaphragms should be relied on to protect women against HIV infection. The role of spermicides, sponges, and diaphragms for preventing transmission of HIV to men has not been evaluated. Diaphragm and spermicide use has been associated with an increased risk of bacterial urinary tract infection in women.

Condoms and N-9 Vaginal Spermicides

Condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. Distribution of previously purchased condoms lubricated with N-9 spermicide should continue provided the condoms have not passed their expiration date. However, purchase of any additional condoms lubricated with the spermicide N-9 is not recommended because spermicide-coated condoms cost more, have a shorter shelf-life than other lubricated condoms, and have been associated with urinary tract infection in young women.

Rectal Use of N-9 Spermicides

Recent data indicate that N-9 may increase the risk for HIV transmission during vaginal intercourse (*6*). Although similar studies have not been conducted among men who use N-9 spermicide during anal intercourse with other men, N-9 can damage the cells lining the rectum, thus providing a portal of entry for HIV and other sexually transmissible agents. Therefore, N-9 should not be used as a microbicide or lubricant during anal intercourse.

Nonbarrier Contraception, Surgical Sterilization, and Hysterectomy

Women who are not at risk for pregnancy might incorrectly perceive themselves to be at no risk for STDs, including HIV infection. Contraceptive methods that are not mechanical or chemical barriers offer no protection against HIV or other STDs. Women who use hormonal contraception (e.g., oral contraceptives, Norplant™, and Depo-Provera™), have intrauterine devices (IUDs), have been surgically sterilized, or have had hysterectomies should be counseled regarding the use of condoms and the risk for STDs, including HIV infection.

STD/HIV Prevention Counseling

Interactive counseling approaches directed at a patient's personal risk, the situations in which risk occurs, and use of goal-setting strategies are effective in STD prevention (*8*). One such approach — "client-centered" HIV prevention counseling — involves two sessions, each lasting 15–20 minutes, and has been recommended for STD clinic patients who receive HIV testing. In addition to prevention counseling, certain videos and large group presentations that provide explicit information about how to use condoms correctly have been effective in reducing the occurrence of additional STDs among persons at high risk, including STD clinic patients and adolescents. Results from randomized controlled trials demonstrate that compared with traditional approaches to providing information, certain brief risk reduction counseling approaches can reduce the occurrence of new sexually transmitted infections by 25%–40% among STD clinic patients (*9*).

Interactive counseling strategies can be effectively used by most health-care providers, regardless of educational background or demographic profile. High-quality counseling is best ensured when clinicians are provided basic training in prevention counseling methods and skills building approaches, periodic supervisor observation of counseling with immediate feedback to counselors, periodic counselor and/or patient satisfaction evaluations, and regularly scheduled meetings of counselors and supervisors to discuss difficult situations. Prevention counseling is believed to be more effective if provided in a non-judgmental manner appropriate to the patient's culture, language, sex, sexual orientation, age, and developmental level.

Partner Notification

Partner notification, once referred to as "contact tracing" but more recently included in the broader category of partner services, is the process of learning from persons with STDs about their sexual partners and helping to arrange for evaluation and treatment of those partners. Providers can furnish this service directly or with assistance from state and local health departments. The intensity of services and the specific conditions for which such services are offered by health agencies vary from area to area. Such services usually are accompanied by health counseling and may include referral of patients and their partners for other services.

Many persons benefit from partner notification; thus, providers should encourage their patients to make partners aware of potential STD risk and urge them to seek diagnosis and treatment, regardless of assistance from local health agencies. However, whether the process of partner notification effectively decreases exposure to STDs from a person's sexual environment or whether it changes the incidence and prevalence of disease is uncertain. The paucity of supporting evidence regarding the consequences of partner notification has spurred the exploration of alternative approaches. One such approach is to place partner notification in the larger context of the sexual and social networks in which people are exposed to STDs. The underlying hypotheses are that networks have an influence on disease transmission that is independent of personal behaviors, that network structure is related directly to prevalence and to underlying disease transmission dynamics, and that network approaches provide a more powerful tool for identifying exposed persons and other persons at risk. A second such approach for which supporting data are being collected is the use of patient delivered therapy for treatment of contacts and others at risk, a technique that can considerably expand the role of practitioners in the control of STDs. The combination of these approaches has the potential to provide both an intervention and its evaluative tool.

These approaches have not yet been sufficiently assessed to warrant definitive recommendations. However, practitioners and public health professionals should be aware of the current potential use of these nontraditional modalities in the prevention and control of STDs.

Reporting and Confidentiality

The accurate identification and timely reporting of STDs are integral components of successful disease control efforts. Timely reporting is important for assessing morbidity trends,

targeting limited resources, and assisting local health authorities in identifying sex partners who may be infected. STD/HIV and acquired immunodeficiency syndrome (AIDS) cases should be reported in accordance with local statutory requirements.

Syphilis, gonorrhea, chlamydia, and AIDS are reportable diseases in every state. HIV infection and chancroid are reportable in many states. The requirements for reporting other STDs differ by state, and clinicians should be familiar with local reporting requirements. Reporting can be provider- and/or laboratory-based. Clinicians who are unsure of local reporting requirements should seek advice from local health departments or state STD programs.

STD and HIV reports are kept strictly confidential. In most jurisdictions, such reports are protected by statute from subpoena. Before public health representatives conduct a follow-up of a positive STD-test result, they should consult the patient's health-care provider to verify the diagnosis and treatment.

Special Populations

Pregnant Women

Intrauterine or perinatally transmitted STDs can have severely debilitating effects on pregnant women, their partners, and their fetuses. All pregnant women and their sex partners should be asked about STDs, counseled about the possibility of perinatal infections, and ensured access to treatment, if needed.

Recommended Screening Tests

- All pregnant women should be offered voluntary HIV testing at the first prenatal visit. Reasons for refusal of testing should be explored, and testing should be reoffered to pregnant women who initially declined testing. Retesting in the third trimester (preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, or have HIV-infected partners). In addition, women who have not received prenatal counseling should be encouraged to be tested for HIV infection at delivery.
- A serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. In populations in which use of prenatal care is not optimal, rapid plasma reagin (RPR)-card test screening (and treatment, if that test is reactive) should be performed at the time a pregnancy is confirmed. Patients who are at high risk for syphilis, are living in areas of excess syphilis morbidity, are previously untested, or have positive serology in the first trimester should be screened again early in the third trimester (28 weeks' gestation) and at delivery. Some states require all women to be screened at delivery. Infants should not be discharged from the hospital unless the syphilis serologic status of the mother has been determined at least one time during pregnancy and preferably again at delivery. Any woman who delivers a stillborn infant should be tested for syphilis.
- A serologic test for hepatitis B surface antigen (HBsAg) should be performed on all pregnant women at the first prenatal visit. HBsAg testing should be repeated late in pregnancy for women who are HBsAg negative but who are at high risk for HBV infection (e.g., injection-drug users and women who have concomitant STDs).
- A test for *Chlamydia trachomatis* should be performed at the first prenatal visit. Women aged <25 years and those at increased risk for chlamydia (i.e., women who have a new or more than one sex partner) also should be tested during the third trimester to prevent maternal postnatal complications and chlamydial infection in the infant. Screening during the first trimester might enable prevention of adverse effects of chlamydia during pregnancy. However, evidence for preventing adverse effects during pregnancy is lacking. If screening is performed only during the first trimester, a longer period exists for acquiring infection before delivery.
- A test for *Neisseria gonorrhoeae* should be performed at the first prenatal visit for women at risk or for women living in an area in which the prevalence of *N. gonorrhoeae* is high. A repeat test should be performed during the third trimester for those at continued risk.
- A test for hepatitis C antibodies (anti-HCV) should be performed at the first prenatal visit for pregnant women at high risk for exposure. Women at high risk include those with a history of injection-drug use, repeated exposure to blood products, prior blood transfusion, or organ transplants.
- Evaluation for bacterial vaginosis (BV) may be conducted at the first prenatal visit for asymptomatic patients who are at high risk for preterm labor (e.g., those who have a history of a previous preterm delivery). Current evidence does not support routine testing for BV.
- A Papanicolaou (Pap) smear should be obtained at the first prenatal visit if none has been documented during the preceding year.

Other Concerns

Other STD-related concerns are as follows.

- HBsAg-positive women should be reported to the local and/or state health department to ensure that they are

entered into a case-management system and that appropriate prophylaxis is provided for their infants. In addition, household and sex contacts of HBsAg-positive women should be vaccinated.

- No treatment is available for anti-HCV-positive pregnant women. However, all women found to be anti-HCV-positive should receive appropriate counseling (see Hepatitis C, Prevention). No vaccine is available to prevent HCV transmission.
- In the absence of lesions during the third trimester, routine serial cultures for HSV are not indicated for women who have a history of recurrent genital herpes. Prophylactic cesarean section is not indicated for women who do not have active genital lesions at the time of delivery.
- The presence of genital warts is not an indication for cesarean section.
- Not enough evidence exists to recommend routine screening for *Trichomonas vaginalis* in asymptomatic pregnant women.

For a more detailed discussion of these guidelines, as well as infections not transmitted sexually, refer to the following references: *Guide to Clinical Preventive Services* (*10*), *Guidelines for Perinatal Care* (*11*), *American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Antimicrobial Therapy for Obstetric Patients* (*12*), *ACOG Committee Opinion: Primary and Preventive Care: Periodic Assessments* (*13*), *Recommendations for the Prevention and Management of* Chlamydia trachomatis *Infections (14), Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States through Universal Childhood Vaccination — Recommendations of the Immunization Practices Advisory Committee (ACIP) (1), Mother-to-infant transmission of hepatitis C virus (15)*, *Hepatitis C: Screening in pregnancy* (*16*), *American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Viral hepatitis in pregnancy* (*17*), *Human Immunodeficiency Virus Screening: Joint statement of the AAP and ACOG* (*18*), *Preventing Perinatal Transmission of HIV* (*19*), and the *Revised Public Health Service Recommendations for HIV Screening of Pregnant Women (20)*.

These sources are not entirely consistent in their recommendations. The *Guide to Clinical Preventive Services* recommends screening of patients at high risk for chlamydia, but indicates that the optimal timing for screening is uncertain. The *Guidelines for Perinatal Care* recommend that pregnant women at high risk for chlamydia be screened for infection during the first prenatal-care visit and during the third trimester. Recommendations to screen pregnant women for STDs are based on disease severity and sequelae, prevalence in the population, costs, medicolegal considerations (e.g., state laws), and other factors. The screening recommendations in this report are more extensive (i.e., if followed, more women will be screened for more STDs than would be screened by following other recommendations) and are compatible with other CDC guidelines.

Adolescents

Health professionals who provide care for adolescents should be aware of several issues that relate specifically to persons within this age group. The rates of many STDs are highest among adolescents. For example, the reported rates of chlamydia and gonorrhea are highest among females aged 15–19 years, and young adults are also at highest risk for HPV infection. In addition, surveillance data indicate that 9% of adolescents who have acute HBV infection either have had sexual contact with a chronically infected person or with multiple sex partners or report their sexual preference as homosexual. As part of a comprehensive strategy to eliminate HBV transmission in the United States, ACIP has recommended that all children be administered hepatitis B vaccine (*1*).

Younger adolescents (i.e., persons aged <15 years) who are sexually active are at particular risk for infection. Adolescents at especially high risk for STDs include youth in detention facilities, STD clinic patients, male homosexuals, and injection-drug users. Adolescents are at greater risk for STDs because they frequently have unprotected intercourse, are biologically more susceptible to infection, are engaged in partnerships often of limited duration, and face multiple obstacles to utilization of health care. Several of these issues can be addressed by clinicians who provide services to adolescents. Clinicians can address the lack of knowledge and awareness about the risks and consequences of STDs and offer guidance, constituting true primary prevention, to help adolescents develop healthy sexual behaviors and thus prevent the establishment of patterns of behavior that can undermine sexual health.

With a few exceptions, all adolescents in the United States can consent to the confidential diagnosis and treatment of STDs. Medical care for STDs can be provided to adolescents without parental consent or knowledge. Furthermore, in many states adolescents can consent to HIV counseling and testing. Consent laws for vaccination of adolescents differ by state. Several states consider provision of vaccine similar to treatment of STDs and provide vaccination services without parental consent. Health-care providers should acknowledge the importance of confidentiality for adolescents and should strive to follow policies that comply with state laws to ensure the confidentiality of STD-related services.

Despite the prevalence of STDs among adolescents, providers frequently fail to inquire about sexual behavior, assess risk for STDs, counsel about risk reduction, and screen for asymptomatic infection during clinical encounters. When

addressing these sensitive areas with young people, the style and content of counseling and health education should be adapted for adolescents. Discussions should be appropriate for the patient's developmental level and should identify risky behaviors (e.g., sex and drug-use behaviors). Careful counseling and thorough discussions are particularly important for adolescents who may not acknowledge that they engage in high-risk behaviors. Care and counseling should be direct and nonjudgmental.

Children

Management of children who have STDs requires close cooperation between clinicians, laboratorians, and child-protection authorities. Investigations, when indicated, should be initiated promptly. Some diseases (e.g., gonorrhea, syphilis, and chlamydia), if acquired after the neonatal period, are almost 100% indicative of sexual contact. For other diseases (e.g., HPV infection and vaginitis), the association with sexual contact is not as clear (see Sexual Assault and STDs).

Men Who Have Sex with Men

Some MSM are at high risk for HIV infection and other viral and bacterial STDs. Although the frequency of unsafe sexual practices and reported rates of bacterial STDs and incident HIV infection has declined substantially in MSM during the last several decades, increased rates of infectious syphilis, gonorrhea, and chlamydial infection, largely among HIV-infected MSM, have been recently reported in many cities in the United States and other industrialized countries. Preliminary data also indicate higher frequencies of unsafe sex and suggest that the incidence of HIV infection may be rising among MSM in some cities. The underlying behavioral changes likely are related to effects of improved HIV/AIDS therapy on quality of life and survival, "safer sex burnout," and in some cities, adverse trends in substance abuse.

Clinicians should assess sexual risk for all male patients, which includes routinely inquiring about the sex of patients' sex partners. MSM, including those with HIV infection, should routinely undergo straightforward, nonjudgmental STD/HIV risk assessment and client-centered prevention counseling to reduce the likelihood of acquisition or transmission of HIV and other STDs. In addition, screening for STDs should be considered for many MSM. The following screening recommendations are based on preliminary data; these tests should be performed at least annually for sexually active MSM:

- HIV serology, if HIV-negative or not previously tested;
- syphilis serology;
- urethral culture or nucleic acid amplification test for gonorrhea;
- a urethral or urine test (culture or nucleic acid amplification) for chlamydia in men with oral-genital exposure;
- pharyngeal culture for gonorrhea in men with oral-genital exposure; and
- rectal gonorrhea and chlamydia culture in men who have had receptive anal intercourse.

In addition, vaccination against hepatitis is the most effective means of preventing sexual transmission of hepatitis A and B. Prevaccination serologic testing may be cost-effective in MSM, among whom the prevalence of hepatitis A and B infection is likely to be high.

More frequent STD screening (e.g., at 3–6-month intervals) may be indicated for MSM at highest risk (e.g., those who acknowledge having multiple anonymous partners or having sex in conjunction with illicit drug use and patients whose sex partners participate in these activities). Screening tests usually are indicated regardless of a patient's history of consistent use of condoms for insertive or receptive anal intercourse. Providers also should be knowledgeable about the common manifestations of symptomatic STDs in MSM (e.g., urethral discharge, dysuria, anorectal symptoms [such as pain, pruritis, discharge, and bleeding], genital or anorectal ulcers, other mucocutaneous lesions, lymphadenopathy, and skin rash). If these symptoms are present, providers should perform appropriate diagnostic tests.

HIV Infection: Detection, Counseling, and Referral

Infection with HIV produces a spectrum of disease that progresses from a clinically latent or asymptomatic state to AIDS as a late manifestation. The pace of disease progression varies. In untreated patients, the time between infection with HIV and the development of AIDS ranges from a few months to as long as 17 years (median: 10 years). Most adults and adolescents infected with HIV remain symptom-free for extended periods, but viral replication is active during all stages of infection, increasing substantially as the immune system deteriorates. In the absence of treatment, AIDS eventually develops in almost all HIV-infected persons; in one study of HIV-infected adults, AIDS developed in 87% within 17 years of infection. Additional cases are expected to occur among those who have remained AIDS-free for longer periods of time.

Greater awareness among both patients and health-care providers of the risk factors associated with HIV transmission has led to increased testing for HIV and earlier diagnosis of the

infection, often before symptoms develop. Prompt diagnosis of HIV infection is important for several reasons. Treatments are available that slow the decline of immune system function; use of these therapies has been associated with substantial declines in HIV-associated morbidity and mortality in recent years. HIV-infected persons who have altered immune function are at increased risk for infections for which preventive measures are available (e.g., *Pneumocystis carinii* pneumonia [PCP], toxoplasmic encephalitis [TE], disseminated *Mycobacterium avium* complex [MAC] disease, tuberculosis [TB], and bacterial pneumonia). Because of its effect on the immune system, HIV affects the diagnosis, evaluation, treatment, and follow-up of many other diseases and may affect the efficacy of antimicrobial therapy for some STDs. Finally, the early diagnosis of HIV enables health-care providers to counsel such patients, refer them to various support services, and help prevent HIV transmission to others.

Proper management of HIV infection involves a complex array of behavioral, psychosocial, and medical services. Although some of these services may be available in the STD treatment facility, many services are often unavailable in this setting. Therefore, referral to a health-care provider or facility experienced in caring for HIV-infected patients is advised. Staff in STD treatment facilities should be knowledgeable about the options for referral available in their communities. While in STD treatment facilities, HIV-infected patients should be educated about HIV infection and the various options for available support services and HIV care.

Because multiple, complex services are required for management of HIV infection, detailed information (particularly regarding medical care) is beyond the scope of this section and can be found elsewhere (*8,21*). This report provides information regarding diagnostic testing for HIV infection, counseling patients who have HIV infection, and referral of patients to support services (including medical care). Information also is provided regarding the management of sex partners, because such services can and should be provided in STD treatment facilities. In addition, the topics of HIV infection during pregnancy and in infants and children are addressed.

Detection of HIV Infection: Diagnostic Testing

Testing for HIV is recommended and should be offered to all persons who seek evaluation and treatment for STDs. Counseling before and after testing (i.e., pretest and posttest counseling) is an integral part of the testing procedure (see HIV Prevention Counseling). Informed consent must be obtained before an HIV test is performed. Some states require written consent.

HIV infection usually is diagnosed by tests for antibodies against HIV-1 and HIV-2 (HIV-1/2). Antibody testing begins with a sensitive screening test (e.g., the enzyme immunoassay [EIA]). Reactive screening tests must be confirmed by supplemental test (e.g., the Western blot [WB]) or an immunofluorescence assay (IFA). If confirmed by a supplemental test, a positive antibody test result indicates that a person is infected with HIV and is capable of transmitting the virus to others. HIV antibody is detectable in at least 95% of patients within 3 months after infection. Although a negative antibody test result usually indicates that a person is not infected, antibody tests cannot exclude recent infection.

Most HIV infections in the United States are caused by HIV-1; <100 cases of HIV-2 infection have been documented (*22*). However, HIV-2 infection should be suspected in persons who have epidemiologic risk factors for HIV-2. Examples of these risk factors include persons with sex partners from West Africa (where HIV-2 is endemic), those with sex partners known to be infected with HIV-2, and persons who received a blood transfusion or a non-sterile injection in a West African country. HIV-2 testing is also indicated when clinical evidence of HIV exists but tests for antibodies to HIV-1 are not positive, or when HIV-1 Western blot results include the unusual indeterminate pattern of *gag* plus *pol* bands in the absence of *env* bands (*22*).

Health-care providers should be knowledgeable about the symptoms and signs of acute retroviral syndrome, which is characterized by fever, malaise, lymphadenopathy, and skin rash. This syndrome frequently occurs in the first few weeks after HIV infection, before antibody test results become positive. Suspicion of acute retroviral syndrome should prompt nucleic acid testing (HIV plasma RNA [i.e., viral load]) to detect the presence of HIV, although this test is not approved for diagnostic purposes; a positive test should be confirmed by another HIV test. Current guidelines suggest that persons with recently acquired HIV infection might benefit from antiretroviral drugs, and such patients may be candidates for clinical trials (*23,24*). Therefore, patients with acute HIV infection should be referred immediately to an HIV clinical care provider.

Detection of HIV infection should prompt efforts to reduce the risk behavior that resulted in HIV infection and could result in transmission of HIV to others. Early counseling and education are particularly important for persons with recently acquired infection, because HIV plasma RNA levels are characteristically high during this phase of infection and likely constitute a risk factor for HIV transmission.

The following are specific recommendations for diagnostic testing for HIV infection.

- HIV testing is recommended and should be offered to all persons who seek evaluation and treatment for STDs.
- Informed consent must be obtained before an HIV test is performed; some states require written consent.
- Positive screening tests for HIV antibody must be confirmed by a more specific confirmatory test (either WB or IFA) before being considered diagnostic of HIV infection.
- Patients who have positive HIV test results must receive initial counseling on-site and should either a) receive behavioral, psychosocial, and medical evaluation and monitoring services or b) be referred for these services.
- Providers should be alert to the possibility of acute retroviral syndrome and should perform nucleic acid testing for HIV, if indicated. Patients suspected of having recently acquired HIV infection should be referred for immediate consultation with a specialist.

Counseling for Patients with HIV Infection and Referral to Support Services

Patients can be expected to be distressed when first informed of a positive HIV test result. Such patients face several major adaptive challenges, including a) accepting the possibility of a shortened life span, b) coping with others' reactions to a stigmatizing illness, c) developing and adopting strategies for maintaining physical and emotional health, and d) initiating changes in behavior to prevent HIV transmission to others. Many patients also require assistance with making reproductive choices, gaining access to health services, and confronting possible employment or housing discrimination. Therefore, in addition to medical care, behavioral and psychosocial services are an integral part of health care for HIV-infected patients. Such services should be available on site or through referral when HIV infection is diagnosed. A comprehensive discussion of specific recommendations is available in the *Guidelines for HIV Counseling, Testing, and Referral (8)*.

Practice settings for offering HIV care differ depending on local resources and needs. Primary-care providers and outpatient facilities must ensure that appropriate resources are available for each patient to avoid fragmentation of care. Although a single source that is capable of providing comprehensive care for all stages of HIV infection is preferred, the limited availability of such resources often results in the need to coordinate care among medical and social service providers in different locations. Providers should avoid long delays between diagnosis of HIV infection and access to additional medical and psychosocial services.

Recently identified HIV infection may not have been recently acquired. Persons newly diagnosed with HIV may be at any stage of infection. Therefore, health-care providers should be alert for symptoms or signs that suggest advanced HIV infection (e.g., fever, weight loss, diarrhea, cough, shortness of breath, and oral candidiasis). The presence of any of these symptoms should prompt urgent referral for medical care. Similarly, providers should be alert for signs of psychologic distress and be prepared to refer patients accordingly.

Diagnosis of HIV infection reinforces the need to counsel patients regarding high risk behaviors, because the consequences of such behaviors include the risk for acquiring additional STDs and for transmitting HIV (and other STDs) to other persons. Such attention to behaviors in HIV-infected persons is consistent with national strategies for HIV prevention (*25*). Providers should be able to refer patients for prevention counseling and risk reduction support concerning high risk behaviors (e.g., substance abuse and high risk sexual behavior).

HIV-infected patients in the STD treatment setting should be educated about what to expect as they enter medical care for HIV infection. In non-emergent situations, the initial evaluation of HIV-positive patients usually includes a) a detailed medical history, including sexual and substance-abuse history, previous STDs, and specific HIV-related symptoms or diagnoses; b) a physical examination (including a gynecologic examination for women); c) testing for *N. gonorrhoeae* and *C. trachomatis* (and for women, a Pap test and wet mount examination of vaginal secretions); d) complete blood and platelet counts and blood chemistry profile; e) toxoplasma antibody test; f) tests for hepatitis B, C, and for MSM, hepatitis A; g) syphilis serology; h) a CD4+ T-lymphocyte analysis and determination of HIV plasma RNA (i.e., HIV viral load); i) a tuberculin skin test (TST) (sometimes referred to as a purified protein derivative [PPD]); j) a urinalysis; and k) a chest radiograph (*21*).

In subsequent visits, once the results of laboratory and skin tests are available, the patient may be offered antiretroviral therapy (*23,24*), if indicated, as well as specific medications to reduce the incidence of opportunistic infections (e.g., PCP, TE, disseminated MAC infection, and TB) (*21,26*). Hepatitis B vaccination should be offered to patients who lack hepatitis B serologic markers. Hepatitis A vaccination should be given to persons at increased risk for hepatitis A infection (e.g., MSM and illegal drug users) and to patients with chronic hepatitis B or hepatitis C who lack antibodies to hepatitis A. Influenza vaccination should be offered annually, and pneumococcal vaccination should be administered if not given in the previous 5 years (*21*).

Providers must be alert to the possibility of new or recurrent STDs and treat such conditions aggressively. Occurrence of an STD in an HIV-infected person is an indication of high-risk behavior and should prompt referral for counseling. Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis, gonorrhea, and chlamydia) should be performed at least yearly for sexually active persons. More frequent screening may be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms.

Patients should receive, or be referred for, a thorough psychosocial evaluation, including ascertainment of behavioral factors indicating risk for transmitting HIV. Patients may require referral for specific behavioral intervention (e.g., a substance abuse program), for mental health disorders (e.g., depression), or for emotional distress. They may require assistance with securing and maintaining employment and housing. Women should be counseled or appropriately referred regarding reproductive choices and contraceptive options. Patients with multiple psychosocial problems may be candidates for prevention case management (*27*).

The following are specific recommendations for counseling and referral.

- Persons who test positive for HIV antibody should be counseled, either on site or through referral, about the behavioral, psychosocial, and medical implications of HIV infection.
- Health-care providers should be alert for medical or psychosocial conditions that require immediate attention.
- Providers should assess persons for immediate care and support needs and link them to services in which health-care personnel are experienced in providing care for HIV-infected patients, including services for medical care, substance abuse, mental health disorders, emotional distress, reproductive counseling, risk-reduction counseling, and prevention management. HIV-infected persons should be referred to these services as needed and followed up to ensure that referrals have been completed.
- Patients should be educated about what to expect in follow-up medical care.

Management of Sex Partners and Injection-Drug Partners

Clinicians evaluating HIV-infected persons should collect information to determine whether any partners should be notified about possible exposure to HIV (*8*). When referring to persons who are infected with HIV, the term "partner" includes not only sex partners but also injection-drug users who share syringes or other injection equipment. The rationale for partner notification is that the early diagnosis and treatment of HIV infection in these partners possibly reduces morbidity and provides the opportunity to encourage risk-reducing behaviors. Partner notification for HIV infection must be confidential and depends on the voluntary cooperation of the patient.

Two complementary notification processes, patient referral and provider referral, can be used to identify partners. With patient referral, patients directly inform their partners of their exposure to HIV infection. With provider referral, trained health department personnel locate partners on the basis of the names, descriptions, and addresses provided by the patient. During the notification process, the confidentiality of patients is protected; their names are not revealed to partners who are notified. Many state health departments provide assistance, if requested, with provider-referral partner notification.

The following are specific recommendations for implementing partner-notification procedures.

- HIV-infected patients should be encouraged to notify their partners and to refer them for counseling and testing. If requested by the patient, health-care providers should assist in this process, either directly or by referral to health department partner-notification programs.
- If patients are unwilling to notify their partners, or if they cannot ensure that their partners will seek counseling, physicians or health department personnel should use confidential procedures to notify partners.

Special Considerations

Pregnancy

Voluntary counseling and HIV testing should be offered routinely to all pregnant women as early in pregnancy as possible (*20*). For women who decline these services, providers should continue to strongly encourage testing and to address concerns that pose obstacles to testing. Providing pregnant women with counseling and testing is particularly important not only to maintain the health of the patient, but also because interventions (antiretroviral and obstetrical) are available that can reduce perinatal transmission of HIV.

Once identified as being HIV-infected, pregnant women should be informed specifically about the risk for perinatal infection. Current evidence indicates that, in the absence of antiretroviral and other interventions, 15%–25% of infants born to HIV-infected mothers will become infected with HIV; such evidence also indicates that an additional 12%–14% are infected during breastfeeding in resource-limited settings where HIV-infected women breastfeed their infants into the second

year of life (*28*). However, the risk of HIV transmission can be reduced substantially to ≤2% through antiretroviral regimens and obstetrical interventions (i.e., AZT or nevirapine and elective c-section at 38 weeks of pregnancy) and by avoiding breastfeeding (*29*). Pregnant women who are HIV-infected should be counseled about their options (either on-site or by referral), given appropriate antenatal treatment, and (for women living in the United States, where infant formula is readily available and can be safely prepared) advised not to breastfeed their infants.

HIV Infection Among Infants and Children

Diagnosis of HIV infection in a pregnant woman indicates the need to consider whether additional children are infected. Infants and young children with HIV infection differ from adults and adolescents with respect to the diagnosis, clinical presentation, and management of HIV disease. For example, because maternal HIV antibody passes through the placenta, antibody tests for HIV are expected to be positive in the sera of both infected and uninfected infants born to seropositive mothers. A definitive determination of HIV infection for an infant aged <18 months should be based on laboratory evidence of HIV in blood or tissues by culture, nucleic acid, or antigen detection. Management of infants, children, and adolescents who are known or suspected to be infected with HIV requires referral to physicians familiar with the manifestations and treatment of pediatric HIV infection (*21,30*).

Diseases Characterized by Genital Ulcers

Management of Patients Who Have Genital Ulcers

In the United States, most young, sexually active patients who have genital ulcers have either genital herpes, syphilis, or chancroid. The relative frequency of each differs by geographic area and patient population; however, genital herpes is the most prevalent of these diseases. More than one of these diseases sometimes is present in a patient who has genital ulcers. Each disease has been associated with an increased risk for HIV infection. Not all genital ulcers are caused by sexually transmitted infections.

A diagnosis based only on the patient's medical history and physical examination often is inaccurate. Therefore, evaluation of all patients who have genital ulcers should include a serologic test for syphilis and a diagnostic evaluation for genital herpes; in settings where chancroid is prevalent, a test for *Haemophilus ducreyi* should also be performed. Specific tests for evaluation of genital ulcers include

- serology, and either darkfield examination or direct immunofluorescence test for *T. pallidum*;
- culture or antigen test for herpes simplex virus (HSV); and
- culture for *H. ducreyi*.

No FDA-approved PCR test for these organisms is available in the United States, but such testing can be performed by commercial laboratories that have developed their own PCR tests. Type-specific serology for HSV type 2 may be helpful in identifying persons with genital herpes (see Genital Herpes). Biopsy of ulcers may be helpful in identifying the cause of unusual ulcers or ulcers that do not respond to initial therapy.

HIV testing should be performed in the management of patients who have genital ulcers caused by *T. pallidum* or *H. ducreyi*. Such testing should be considered for those who have ulcers caused by HSV (see sections on Syphilis, Chancroid, and Genital Herpes).

Health-care providers often must treat patients before test results are available because early treatment decreases the possibility of ongoing transmission and because successful treatment of genital herpes depends upon prompt initiation of therapy. In this circumstance, the clinician should treat for the diagnosis considered most likely on the basis of clinical presentation and epidemiologic circumstances. Sometimes treatment must be initiated for additional conditions because of diagnostic uncertainty. Even after complete diagnostic evaluation, at least 25% of patients who have genital ulcers have no laboratory-confirmed diagnosis.

Chancroid

In the United States, chancroid usually occurs in discrete outbreaks, although the disease is endemic in some areas. Chancroid is a cofactor for HIV transmission; high rates of HIV infection among patients who have chancroid occur in the United States and other countries. About 10% of persons who have chancroid acquired in the United States are coinfected with *T. pallidum* or HSV; this percentage is higher in persons acquiring chancroid outside the United States.

A definitive diagnosis of chancroid requires identification of *H. ducreyi* on special culture media that is not widely available from commercial sources; even using these media, sensitivity is ≤80%. No FDA-approved PCR test for *H. ducreyi* is available in the United States, but such testing can be performed by commercial laboratories that have developed their own PCR test. A probable diagnosis, for both clinical and surveillance purposes, can be made if all the following criteria are met: a) the patient has one or more painful genital ulcers; b) the patient has no evidence of *T. pallidum* infection by

darkfield examination of ulcer exudate or by a serologic test for syphilis performed at least 7 days after onset of ulcers; c) the clinical presentation, appearance of genital ulcers and, if present, regional lymphadenopathy are typical for chancroid; and d) a test for HSV performed on the ulcer exudate is negative. The combination of a painful ulcer and tender inguinal adenopathy, symptoms occurring in one third of patients, suggests a diagnosis of chancroid; when accompanied by suppurative inguinal adenopathy, these signs are almost pathognomonic.

Treatment

Successful treatment for chancroid cures the infection, resolves the clinical symptoms, and prevents transmission to others. In advanced cases, scarring can result despite successful therapy.

Recommended Regimens

Azithromycin 1 g orally in a single dose,
OR
Ceftriaxone 250 mg intramuscularly (IM) in a single dose,
OR
Ciprofloxacin 500 mg orally twice a day for 3 days,
OR
Erythromycin base 500 mg orally three times a day for 7 days.

NOTE: Ciprofloxacin is contraindicated for pregnant and lactating women.

Azithromycin and ceftriaxone offer the advantage of single-dose therapy. Worldwide, several isolates with intermediate resistance to either ciprofloxacin or erythromycin have been reported.

Other Management Considerations

Patients who are uncircumcised and patients with HIV infection do not respond as well to treatment as those who are circumcised or HIV-negative. Patients should be tested for HIV infection at the time chancroid is diagnosed. Patients should be retested for syphilis and HIV 3 months after the diagnosis of chancroid if the initial test results were negative.

Follow-Up

Patients should be re-examined 3–7 days after initiation of therapy. If treatment is successful, ulcers usually improve symptomatically within 3 days and objectively within 7 days after therapy. If no clinical improvement is evident, the clinician must consider whether a) the diagnosis is correct, b) the patient is coinfected with another STD, c) the patient is infected with HIV, d) the treatment was not used as instructed, or e) the *H. ducreyi* strain causing the infection is resistant to the prescribed antimicrobial. The time required for complete healing depends on the size of the ulcer; large ulcers may require >2 weeks. In addition, healing is slower for some uncircumcised men who have ulcers under the foreskin. Clinical resolution of fluctuant lymphadenopathy is slower than that of ulcers and may require needle aspiration or incision and drainage, despite otherwise successful therapy. Although needle aspiration of buboes is a simpler procedure, incision and drainage may be preferred because of reduced need for subsequent drainage procedures.

Management of Sex Partners

Sex partners of patients who have chancroid should be examined and treated, regardless of whether symptoms of the disease are present, if they had sexual contact with the patient during the 10 days preceding the patient's onset of symptoms.

Special Considerations

Pregnancy

The safety and efficacy of azithromycin for pregnant and lactating women have not been established. Ciprofloxacin is contraindicated during pregnancy and lactation. No adverse effects of chancroid on pregnancy outcome have been reported.

HIV Infection

HIV-infected patients who have chancroid should be monitored closely because, as a group, these patients are more likely to experience treatment failure and to have ulcers that heal more slowly. HIV-infected patients may require longer courses of therapy than those recommended for HIV-negative patients, and treatment failures can occur with any regimen. Because data are limited concerning the therapeutic efficacy of the recommended ceftriaxone and azithromycin regimens in HIV-infected patients, these regimens should be used for such patients only if follow-up can be ensured. Some specialists suggest using the erythromycin 7-day regimen for treating HIV-infected persons.

Genital Herpes Simplex Virus Infections

Genital herpes is a recurrent, life-long viral infection. Two serotypes of HSV have been identified: HSV-1 and HSV-2. Most cases of recurrent genital herpes are caused by HSV-2. At least 50 million persons in the United States have genital HSV infection.

Most persons infected with HSV-2 have not been diagnosed. Many such persons have mild or unrecognized infections but shed virus intermittently in the genital tract. Most genital herpes infections are transmitted by persons unaware that they have the infection or who are asymptomatic when transmission

occurs. Rarely, first-episode genital herpes is manifested by severe disease that may require hospitalization.

Diagnosis of HSV Infection

The clinical diagnosis of genital herpes is both insensitive and nonspecific. The typical painful multiple vesicular or ulcerative lesions are absent in many infected persons. Up to 30% of first-episode cases of genital herpes are caused by HSV-1, but recurrences are much less frequent for genital HSV-1 infection than genital HSV-2 infection. Therefore, the distinction between HSV serotypes influences prognosis and counseling. For these reasons, the clinical diagnosis of genital herpes should be confirmed by laboratory testing. Both virologic tests and type-specific serologic tests for HSV should be available in clinical settings that provide care for patients with STDs or those at risk for STDs.

Virologic Tests

Isolation of HSV in cell culture is the preferred virologic test in patients who present with genital ulcers or other mucocutaneous lesions. The sensitivity of culture declines rapidly as lesions begin to heal, usually within a few days of onset. Some HSV antigen detection tests, unlike culture and the direct fluorescent antibody test, do not distinguish HSV-1 from HSV-2. Polymerase chain reaction (PCR) assays for HSV DNA are highly sensitive, but their role in the diagnosis of genital ulcer disease has not been well-defined. However, PCR is available in some laboratories and is the test of choice for detecting HSV in spinal fluid for diagnosis of HSV-infection of the central nervous system (CNS). Cytologic detection of cellular changes of herpes virus infection is insensitive and nonspecific, both in genital lesions (Tzanck preparation) and cervical Pap smears, and should not be relied on for diagnosis of HSV infection.

Type-specific Serologic Tests

Both type-specific and nonspecific antibodies to HSV develop during the first several weeks following infection and persist indefinitely. Because almost all HSV-2 infections are sexually acquired, type-specific HSV-2 antibody indicates anogenital infection, but the presence of HSV-1 antibody does not distinguish anogenital from orolabial infection. Accurate type-specific assays for HSV antibodies must be based on the HSV-specific glycoprotein G2 for the diagnosis of infection with HSV-2 and glycoprotein G1 for diagnosis of infection with HSV-1. Such assays first became commercially available in 1999, but older assays that do not accurately distinguish HSV-1 from HSV-2 antibody, despite claims to the contrary, remain on the market. Therefore, the serologic type-specific gG-based assays should be specifically requested when serology is performed.

Currently, the FDA-approved, gG-based type-specific assays include POCkit™HSV-2 (manufactured by Diagnology); HerpeSelect™-1 ELISA IgG or HerpeSelect™-2 ELISA IgG (manufactured by Focus Technology, Inc.); and HerpeSelect™ 1 and 2 Immunoblot IgG (manufactured by Focus Technology, Inc.). The POCkit™-HSV-2 assay is a point-of-care test that provides results for HSV-2 antibodies from capillary blood or serum during a clinic visit. The Focus Technology assays are laboratory-based. The sensitivities of these tests for detection of HSV-2 antibody vary from 80% to 98%, and false-negative results may occur, especially at early stages of infection. The specificities of these assays are ≥96%. False-positive results can occur, especially in patients with low likelihood of HSV infection. Therefore, repeat testing or a confirmatory test (e.g., an immunoblot assay if the initial test was an ELISA) may be indicated in some settings.

Because false-negative HSV cultures are common, especially in patients with recurrent infection or with healing lesions, type-specific serologic tests are useful in confirming a clinical diagnosis of genital herpes. Additionally, such tests can be used to diagnose persons with unrecognized infection and to manage sex partners of persons with genital herpes. Although serologic assays for HSV-2 should be available for persons who request them, screening for HSV-1 or HSV-2 infection in the general population is not indicated.

Principles of Management of Genital Herpes

Antiviral chemotherapy offers clinical benefits to most symptomatic patients and is the mainstay of management. In addition, counseling regarding the natural history of genital herpes, sexual and perinatal transmission, and methods to reduce transmission is integral to clinical management.

Systemic antiviral drugs partially control the symptoms and signs of herpes episodes when used to treat first clinical episodes and recurrent episodes or when used as daily suppressive therapy. However, these drugs neither eradicate latent virus nor affect the risk, frequency, or severity of recurrences after the drug is discontinued. Randomized trials indicate that three antiviral medications provide clinical benefit for genital herpes: acyclovir, valacyclovir, and famciclovir (*31–41*). Valacyclovir is the valine ester of acyclovir and has enhanced absorption after oral administration. Famciclovir, a pro-drug of penciclovir, also has high oral bioavailability. Topical therapy with antiviral drugs offers minimal clinical benefit, and its use is not recommended.

First Clinical Episode of Genital Herpes

Many patients with first-episode herpes present with mild clinical manifestations but later develop severe or prolonged symptoms. Therefore, most patients with initial genital herpes should receive antiviral therapy.

Recommended Regimens

Acyclovir 400 mg orally three times a day for 7–10 days,
OR
Acyclovir 200 mg orally five times a day for 7–10 days,
OR
Famciclovir 250 mg orally three times a day for 7–10 days,
OR
Valacyclovir 1 g orally twice a day for 7–10 days.

NOTE: Treatment may be extended if healing is incomplete after 10 days of therapy.

Higher dosages of acyclovir (i.e., 400 mg orally five times a day) were used in treatment studies of first-episode herpes proctitis and first-episode oral infection. However, no comparative studies have been conducted, and whether these forms of HSV infection require higher doses of antiviral drugs than used for genital herpes is unknown. Valacyclovir and famciclovir probably are also effective for acute HSV proctitis or oral infection, but clinical experience is lacking.

Recurrent Episodes of HSV Disease

Most patients with symptomatic, first-episode genital HSV-2 infection subsequently experience recurrent episodes of genital lesions; recurrences are much less frequent following initial genital HSV-1 infection. Antiviral therapy for recurrent genital herpes can be administered either episodically, to ameliorate or shorten the duration of lesions, or continuously as suppressive therapy to reduce the frequency of recurrences. Many patients, including those with mild or infrequent recurrent outbreaks, benefit from antiviral therapy; therefore, options for treatment should be discussed with all patients.

Episodic Therapy for Recurrent Genital Herpes

Effective episodic treatment of recurrent herpes requires initiation of therapy within 1 day of lesion onset, or during the prodrome that precedes some outbreaks. The patient should be provided with a supply of drug or a prescription for the medication with instructions to self-initiate treatment immediately when symptoms begin.

Recommended Regimens

Acyclovir 400 mg orally three times a day for 5 days,
OR
Acyclovir 200 mg orally five times a day for 5 days,
OR
Acyclovir 800 mg orally twice a day for 5 days,
OR
Famciclovir 125 mg orally twice a day for 5 days,
OR
Valacyclovir 500 mg orally twice a day for 3–5 days,
OR
Valacyclovir 1.0 g orally once a day for 5 days.

For episodic therapy, a randomized controlled trial indicated that a 3-day course of valacyclovir 500 mg twice daily is as effective as a 5-day course. Similar studies have not been done with acyclovir and famciclovir.

Suppressive Therapy for Recurrent Genital Herpes

Suppressive therapy reduces the frequency of genital herpes recurrences by 70%–80% among patients who have frequent recurrences (i.e., ≥6 recurrences per year), and many patients report no symptomatic outbreaks. Treatment probably is also effective in patients with less frequent recurrences, although definitive data are lacking. Safety and efficacy have been documented among patients receiving daily therapy with acyclovir for as long as 6 years, and with valacyclovir or famciclovir for 1 year. Quality of life often is improved in patients with frequent recurrences who receive suppressive compared with episodic treatment.

The frequency of recurrent outbreaks diminishes over time in many patients, and the patient's psychological adjustment to the disease may change. Therefore, periodically during suppressive treatment (e.g., once a year), discontinuation of therapy should be discussed with the patient to reassess the need for continued therapy.

Suppressive antiviral therapy reduces but does not eliminate subclinical viral shedding. Therefore, the extent to which suppressive therapy prevents HSV transmission is unknown.

Recommended Regimens

Acyclovir 400 mg orally twice a day,
OR
Famciclovir 250 mg orally twice a day,
OR
Valacyclovir 500 mg orally once a day,
OR
Valacyclovir 1.0 gram orally once a day.

Valacyclovir 500 mg once a day might be less effective than other valacyclovir or acyclovir dosing regimens in patients who have very frequent recurrences (i.e., ≥10 episodes per year).

Few comparative studies of valacyclovir or famciclovir with acyclovir have been conducted. The results of these studies suggest that valacyclovir and famciclovir are comparable to acyclovir in clinical outcome (*35–39*). Ease of administration and cost also are important considerations for prolonged treatment.

Severe Disease

IV acyclovir therapy should be provided for patients who have severe disease or complications that necessitate hospitalization, such as disseminated infection, pneumonitis, hepatitis, or complications of the central nervous system (e.g., meningitis or encephalitis). The recommended regimen is acyclovir 5–10 mg/kg body weight IV every 8 hours for 2–7 days or until clinical improvement is observed, followed by oral antiviral therapy to complete at least 10 days total therapy.

Counseling

Counseling of infected persons and their sex partners is critical to management of genital herpes. Counseling has two main goals: to help patients cope with the infection and to prevent sexual and perinatal transmission. Although initial counseling can be provided at the first visit, many patients benefit from learning about the chronic aspects of the disease after the acute illness subsides. Numerous resources, including the CDC National STD/HIV Hotline (tel: 800-227-8922), web sites (http://www.ashastd.org), and printed materials are available to assist patients and clinicians in counseling.

HSV-infected persons may express anxiety about genital herpes that does not reflect the actual clinical severity of their disease; the psychological impact of infection often is substantial. Common concerns about genital herpes include the severity of initial clinical manifestations, recurrent episodes, sexual relationships and transmission to sex partners, and ability to bear healthy children. The misconception that HSV causes cancer should be dispelled, because the role of HSV-2 in cervical cancer is at most that of a cofactor, not a primary etiologic agent.

Specific counseling messages should include the following information.

- Patients who have genital herpes should be educated about the natural history of the disease, with emphasis on the potential for recurrent episodes, asymptomatic viral shedding, and attendant risks of sexual transmission.
- Patients experiencing a first episode of genital herpes should be advised that suppressive and episodic antiviral therapy is available and is effective in preventing or shortening the duration of recurrent episodes.
- All persons with genital HSV infection should be encouraged to inform their current sex partners that they have genital herpes and to inform future partners before initiating a sexual relationship.
- Persons with genital herpes should be informed that sexual transmission of HSV can occur during asymptomatic periods. Asymptomatic viral shedding is more frequent in genital HSV-2 infection than genital HSV-1 infection and is most frequent in the first 12 months of acquiring HSV-2.
- Patients should be advised to abstain from sexual activity with uninfected partners when lesions or prodromal symptoms are present.
- Latex condoms, when used consistently and correctly, can reduce the risk for genital herpes when the infected areas are covered or protected by the condom. A recent prospective study suggests that condoms have been effective in preventing transmission from men to women.
- Sex partners of infected persons should be advised that they might be infected even if they have no symptoms. Type-specific serologic testing of asymptomatic partners of persons with genital herpes can determine whether risk for HSV acquisition exists.
- The risk for neonatal HSV infection should be explained to all patients, including men. Pregnant women and women of childbearing age who have genital herpes should inform their providers who care for them during pregnancy as well as those who will care for their newborn infant. Pregnant women who are not infected with HSV-2 should be advised to avoid intercourse during the third trimester with men who have genital herpes. Similarly, pregnant women who are not infected with HSV-1 should be counseled to avoid genital exposure to HSV-1 during the third trimester (e.g., cunnilingus with a partner with oral herpes and vaginal intercourse with a partner with genital HSV-1 infection).
- Asymptomatic persons diagnosed with HSV-2 infection by type-specific serologic testing should receive the same counseling messages as persons with symptomatic infection. In addition, such persons should be taught about the common manifestations of genital herpes. Antiviral therapy is not recommended for persons who do not have clinical manifestations of infection.

Management of Sex Partners

The sex partners of patients who have genital herpes likely benefit from evaluation and counseling. Symptomatic sex partners should be evaluated and treated in the same manner as patients who have genital lesions. Asymptomatic sex partners

of patients who have genital herpes should be questioned concerning histories of genital lesions, educated to recognize symptoms of herpes, and offered type-specific serologic testing for HSV infection.

Special Considerations

Allergy, Intolerance, and Adverse Reactions

Allergic and other adverse reactions to acyclovir, valacyclovir, and famciclovir are rare. Desensitization to acyclovir has been described *(42)*.

HIV Infection

Immunocompromised patients may have prolonged or severe episodes of genital, perianal, or oral herpes. Lesions caused by HSV are common among HIV-infected patients and may be severe, painful, and atypical. Episodic or suppressive therapy with oral antiviral agents is often beneficial.

Recommended Regimens for Episodic Infection in Persons Infected with HIV

Acyclovir 400 mg orally three times a day for 5–10 days,
OR
Acyclovir 200 mg five times a day for 5–10 days,
OR
Famciclovir 500 mg orally twice a day for 5–10 days,
OR
Valacyclovir 1.0 g orally twice a day for 5–10 days.

Recommended Regimens for Daily Suppressive Therapy in Persons Infected with HIV

Acyclovir 400–800 mg orally twice to three times a day,
OR
Famciclovir 500 mg orally twice a day,
OR
Valacyclovir 500 mg orally twice a day.

In the doses recommended for treatment of genital herpes, acyclovir, valacyclovir, and famciclovir are safe for use in immunocompromised patients. For severe cases, initiating therapy with acyclovir 5–10 mg/kg body weight IV every 8 hours may be necessary.

If lesions persist or recur in a patient receiving antiviral treatment, HSV resistance should be suspected and a viral isolate obtained for sensitivity testing. Such patients should be managed in consultation with a specialist, and alternate therapy should be administered. All acyclovir-resistant strains are resistant to valacyclovir and most are resistant to famciclovir. Foscarnet, 40 mg/kg body weight IV every 8 hours until clinical resolution is attained, is often effective for treatment of acyclovir-resistant genital herpes. Topical cidofovir gel 1% applied to the lesions once daily for 5 consecutive days also might be effective. This preparation is not commercially available and must be compounded at a pharmacy.

Genital Herpes in Pregnancy

Most mothers of infants who acquire neonatal herpes lack histories of clinically evident genital herpes. The risk for transmission to the neonate from an infected mother is high (30%–50%) among women who acquire genital herpes near the time of delivery and is low (<1%) among women with histories of recurrent herpes at term or who acquire genital HSV during the first half of pregnancy. However, because recurrent genital herpes is much more common than initial HSV infection during pregnancy, the proportion of neonatal HSV infections acquired from mothers with recurrent herpes remains high. Prevention of neonatal herpes depends both on preventing acquisition of genital HSV infection during late pregnancy and avoiding exposure of the infant to herpetic lesions during delivery.

Women without known genital herpes should be counseled to avoid intercourse during the third trimester with partners known or suspected of having genital herpes. In addition, pregnant women without known orolabial herpes should be advised to avoid cunnilingus during the third trimester with partners known or suspected to have orolabial herpes. Some specialists believe type-specific serologic tests are useful to identify pregnant women at risk for HSV infection and to guide counseling with regard to the risk of acquiring genital herpes during pregnancy. Such testing and counseling may be especially important when a woman's sex partner has HSV infection.

All pregnant women should be asked whether they have a history of genital herpes. At the onset of labor, all women should be questioned carefully about symptoms of genital herpes, including prodrome, and all women should be examined carefully for herpetic lesions. Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally. Most specialists recommend that women with recurrent genital herpetic lesions at the onset of labor deliver by cesarean section to prevent neonatal herpes. However, abdominal delivery does not completely eliminate the risk for HSV transmission to the infant. The results of viral cultures during pregnancy in women with or without visible herpetic lesions do not predict viral shedding at the time of delivery, and therefore routine viral cultures of pregnant women with recurrent genital herpes are not recommended.

The safety of systemic acyclovir, valacyclovir, and famciclovir therapy in pregnant women has not been established. Available data do not indicate an increased risk for major birth defects compared with the general population in women treated

with acyclovir during the first trimester (*43*). These findings provide some assurance to women who have had prenatal exposure to acyclovir. However, available data are insufficient to reach definitive conclusions regarding the risks to the newborn associated with acyclovir treatment during pregnancy. The experience with prenatal exposure to valacyclovir and famciclovir is too limited to provide useful information on pregnancy outcomes.

Acyclovir may be administered orally to pregnant women with first episode genital herpes or severe recurrent herpes and should be administered IV to pregnant women with severe HSV infection. Preliminary data suggest that acyclovir treatment late in pregnancy might reduce the frequency of cesarean sections among women who have recurrent genital herpes by diminishing the frequency of recurrences at term (*44,45*), and some specialists recommend such treatment. The risk for herpes is high in infants of women who acquire genital HSV in late pregnancy; such women should be managed in consultation with an HSV specialist. Some specialists recommend acyclovir therapy in this circumstance, some recommend routine cesarean section to reduce the risk for neonatal herpes, and others recommend both.

Neonatal Herpes

Infants exposed to HSV during birth, as documented by virologic testing or presumed by observation of lesions, should be followed carefully in consultation with a specialist. Some specialists recommend that such infants undergo surveillance cultures of mucosal surfaces to detect HSV infection before development of clinical signs of neonatal herpes. Some specialists recommend the use of acyclovir for infants born to women who acquired HSV near term, because the risk for neonatal herpes is high for these infants.

All infants who have evidence of neonatal herpes should be promptly evaluated and treated with systemic acyclovir. The recommended regimen for infants treated for known or suspected neonatal herpes is acyclovir 20 mg/kg body weight IV every 8 hours for 21 days for disseminated and CNS disease, or 14 days for disease limited to the skin and mucous membranes.

Granuloma Inguinale (Donovanosis)

Granuloma inguinale is a genital ulcerative disease caused by the intracellular Gram-negative bacterium *Calymmatobacterium granulomatis*. The disease occurs rarely in the United States, although it is endemic in certain tropical and developing areas, including India; Papua, New Guinea; central Australia; and southern Africa. Clinically, the disease commonly presents as painless, progressive ulcerative lesions without regional lymphadenopathy. The lesions are highly vascular ("beefy red appearance") and bleed easily on contact. However, the clinical presentation can also include hypertrophic, necrotic, or sclerotic variants. The causative organism is difficult to culture, and diagnosis requires visualization of dark-staining Donovan bodies on tissue crush preparation or biopsy. The lesions may develop secondary bacterial infection or may be coinfected with another sexually transmitted pathogen.

Treatment

Treatment halts progression of lesions, although prolonged therapy may be required to permit granulation and reepithelialization of the ulcers. Relapse can occur 6–18 months after apparently effective therapy. Several antimicrobial regimens have been effective, but few controlled trials have been published.

Recommended Regimens

Doxycycline 100 mg orally twice a day for at least 3 weeks

OR

Trimethoprim-sulfamethoxazole one double-strength (800mg/160mg) tablet orally twice a day for at least 3 weeks.

Alternative Regimens

Ciprofloxacin 750 mg orally twice a day for at least 3 weeks,

OR

Erythromycin base 500 mg orally four times a day for at least 3 weeks,

OR

Azithromycin 1 g orally once per week for at least 3 weeks.

Therapy should be continued at least 3 weeks or until all lesions have completely healed. Some specialists recommend addition of an aminoglycoside (e.g., gentamicin 1 mg/kg IV every 8 hours) to the above regimens if improvement is not evident within the first few days of therapy.

Follow-Up

Patients should be followed clinically until signs and symptoms have resolved.

Management of Sex Partners

Persons who have had sexual contact with a patient who has granuloma inguinale within the 60 days before onset of the patient's symptoms should be examined and offered therapy. However, the value of empiric therapy in the absence of clinical signs and symptoms has not been established.

Special Considerations

Pregnancy

Pregnancy is a relative contraindication to the use of sulfonamides. Pregnant and lactating women should be treated with the erythromycin regimen, and consideration should be given to the addition of a parenteral aminoglycoside (e.g., gentamicin). Azithromycin may prove useful for treating granuloma inguinale in pregnancy, but published data are lacking. Doxycycline and ciprofloxacin are contraindicated in pregnant women.

HIV Infection

Persons with both granuloma inguinale and HIV infection should receive the same regimens as those who are HIV negative. Consideration should be given to the addition of a parenteral aminoglycoside (e.g., gentamicin).

Lymphogranuloma Venereum

Lymphogranuloma venereum (LGV) is caused by *C. trachomatis* serovars L1, L2, or L3. The disease occurs rarely in the United States. The most common clinical manifestation of LGV among heterosexuals is tender inguinal and/or femoral lymphadenopathy that is most commonly unilateral. Women and homosexually active men may have proctocolitis or inflammatory involvement of perirectal or perianal lymphatic tissues resulting in fistulas and strictures. A self-limited genital ulcer sometimes occurs at the site of inoculation. However, by the time patients seek care, the ulcer usually has disappeared. The diagnosis of LGV is usually made serologically and by exclusion of other causes of inguinal lymphadenopathy or genital ulcers. Complement fixation titers ≥1:64 are consistent with the diagnosis of LGV. The diagnostic utility of serologic methods other than complement fixation is unknown.

Treatment

Treatment cures infection and prevents ongoing tissue damage, although tissue reaction can result in scarring. Buboes may require aspiration through intact skin or incision and drainage to prevent the formation of inguinal/femoral ulcerations. Doxycycline is the preferred treatment.

Recommended Regimen

Doxycycline 100 mg orally twice a day for 21 days.

Alternative Regimen

Erythromycin base 500 mg orally four times a day for 21 days.

Some STD specialists believe azithromycin 1.0 g orally once weekly for 3 weeks is likely effective, although clinical data are lacking.

Follow-Up

Patients should be followed clinically until signs and symptoms have resolved.

Management of Sex Partners

Persons who have had sexual contact with a patient who has LGV within the 30 days before onset of the patient's symptoms should be examined, tested for urethral or cervical chlamydial infection, and treated.

Special Considerations

Pregnancy

Pregnant and lactating women should be treated with erythromycin. Azithromycin may prove useful for treatment of LGV in pregnancy, but no published data are available regarding its safety and efficacy. Doxycycline is contraindicated in pregnant women.

HIV Infection

Persons with both LGV and HIV infection should receive the same regimens as those who are HIV-negative. Prolonged therapy may be required, and delay in resolution of symptoms may occur.

Syphilis

General Principles

Background

Syphilis is a systemic disease caused by *T. pallidum*. Patients who have syphilis may seek treatment for signs or symptoms of primary infection (i.e., ulcer or chancre at the infection site), secondary infection (i.e., manifestations that include but are not limited to skin rash, mucocutaneous lesions, and lymphadenopathy), or tertiary infection (e.g., cardiac, ophthalmic, auditory abnormalities, and gummatous lesions). Latent infections (i.e., those lacking clinical manifestations) are detected by serologic testing. Latent syphilis acquired within the preceding year is referred to as early latent syphilis; all other cases of latent syphilis are either late latent syphilis or latent syphilis of unknown duration. Treatment for both late latent syphilis and tertiary syphilis theoretically may require a longer duration of therapy because organisms are dividing more slowly; however, the validity of this concept has not been assessed.

Diagnostic Considerations and Use of Serologic Tests

Darkfield examinations and direct fluorescent antibody tests of lesion exudate or tissue are the definitive methods for diagnosing early syphilis. A presumptive diagnosis is possible with the use of two types of serologic tests for syphilis: a) nontreponemal tests (e.g., Venereal Disease Research Laboratory [VDRL] and Rapid Plasma Reagin [RPR]) and b) treponemal tests (e.g., fluorescent treponemal antibody absorbed [FTA-ABS] and *T. pallidum* particle agglutination [TP-PA]). The use of only one type of serologic test is insufficient for diagnosis, because false-positive nontreponemal test results may occur secondary to various medical conditions.

Nontreponemal test antibody titers usually correlate with disease activity, and results should be reported quantitatively. A fourfold change in titer, equivalent to a change of two dilutions (e.g., from 1:16 to 1:4 or from 1:8 to 1:32), is considered necessary to demonstrate a clinically significant difference between two nontreponemal test results that were obtained using the same serologic test. Sequential serologic tests in individual patients should be performed by using the same testing method (e.g., VDRL or RPR), preferably by the same laboratory. The VDRL and RPR are equally valid assays, but quantitative results from the two tests cannot be compared directly because RPR titers often are slightly higher than VDRL titers. Nontreponemal tests usually become nonreactive with time after treatment; however, in some patients, nontreponemal antibodies can persist at a low titer for a long period of time, sometimes for the life of the patient. This response is referred to as the "serofast reaction."

Most patients who have reactive treponemal tests will have reactive tests for the remainder of their lives, regardless of treatment or disease activity. However, 15%–25% of patients treated during the primary stage revert to being serologically nonreactive after 2–3 years. Treponemal test antibody titers correlate poorly with disease activity and should not be used to assess treatment response.

Some HIV-infected patients can have atypical serologic test results (i.e., unusually high, unusually low, or fluctuating titers). For such patients, when serologic tests and clinical syndromes suggestive of early syphilis do not correspond with one another, use of other tests (e.g., biopsy and direct microscopy) should be considered. However, for most HIV-infected patients, serologic tests are accurate and reliable for the diagnosis of syphilis and for following the response to treatment.

No test can be used alone to diagnose neurosyphilis. The VDRL-CSF is highly specific, but it is insensitive. Most other tests are both insensitive and nonspecific and must be interpreted in relation to other test results and the clinical assessment. Therefore, the diagnosis of neurosyphilis usually depends on various combinations of reactive serologic test results, abnormalities of cerebrospinal fluid (CSF) cell count or protein, or a reactive VDRL-CSF with or without clinical manifestations. The CSF leukocyte count usually is elevated (>5 WBCs/mm^3) in patients with neurosyphilis; this count also is a sensitive measure of the effectiveness of therapy. The VDRL-CSF is the standard serologic test for CSF, and when reactive in the absence of substantial contamination of CSF with blood, it is considered diagnostic of neurosyphilis. However, the VDRL-CSF may be nonreactive when neurosyphilis is present. Some specialists recommend performing an FTA-ABS test on CSF. The CSF FTA-ABS is less specific (i.e., yields more false-positive results) for neurosyphilis than the VDRL-CSF, but the test is highly sensitive. Therefore, some specialists believe that a negative CSF FTA-ABS test excludes neurosyphilis.

Treatment

Penicillin G, administered parenterally, is the preferred drug for treatment of all stages of syphilis. The preparation(s) used (i.e., benzathine, aqueous procaine, or aqueous crystalline), the dosage, and the length of treatment depend on the stage and clinical manifestations of disease. However, neither combinations of benzathine penicillin and procaine penicillin nor oral penicillin preparations are considered appropriate for the treatment of syphilis.

The efficacy of penicillin for the treatment of syphilis was well established through clinical experience before the value of randomized controlled clinical trials was recognized. Therefore, almost all the recommendations for the treatment of syphilis are based on the opinions of persons knowledgeable about STDs and are reinforced by case series, clinical trials, and 50 years of clinical experience.

Parenteral penicillin G is the only therapy with documented efficacy for syphilis during pregnancy. Pregnant women with syphilis in any stage who report penicillin allergy should be desensitized and treated with penicillin. Skin testing for penicillin allergy may be useful in pregnant women; such testing also is useful in other patients (see Management of Patients Who Have a History of Penicillin Allergy).

The Jarisch-Herxheimer reaction is an acute febrile reaction frequently accompanied by headache, myalgia, and other symptoms that usually occurs within the first 24 hours after any therapy for syphilis. Patients should be informed about this possible adverse reaction. The Jarisch-Herxheimer reaction occurs most often among patients who have early syphilis. Antipyretics may be used, but they have not been proven to prevent this reaction. The Jarisch-Herxheimer reaction may

induce early labor or cause fetal distress in pregnant women. This concern should not prevent or delay therapy (see Syphilis During Pregnancy).

Management of Sex Partners

Sexual transmission of *T. pallidum* occurs only when mucocutaneous syphilitic lesions are present; such manifestations are uncommon after the first year of infection. However, persons exposed sexually to a patient who has syphilis in any stage should be evaluated clinically and serologically according to the following recommendations.

- Persons who were exposed within the 90 days preceding the diagnosis of primary, secondary, or early latent syphilis in a sex partner might be infected even if seronegative; therefore, such persons should be treated presumptively.
- Persons who were exposed >90 days before the diagnosis of primary, secondary, or early latent syphilis in a sex partner should be treated presumptively if serologic test results are not available immediately and the opportunity for follow-up is uncertain.
- For purposes of partner notification and presumptive treatment of exposed sex partners, patients with syphilis of unknown duration who have high nontreponemal serologic test titers (i.e., ≥1:32) can be assumed to have early syphilis. However, serologic titers should not be used to differentiate early from late latent syphilis for the purpose of determining treatment (see Latent Syphilis, Treatment).
- Long-term sex partners of patients who have latent syphilis should be evaluated clinically and serologically for syphilis and treated on the basis of the evaluation findings.

For identification of at-risk partners, the time periods before treatment are a) 3 months plus duration of symptoms for primary syphilis, b) 6 months plus duration of symptoms for secondary syphilis, and c) 1 year for early latent syphilis.

Primary and Secondary Syphilis

Treatment

Parenteral penicillin G has been used effectively for more than 50 years to achieve clinical resolution (i.e., healing of lesions and prevention of sexual transmission) and to prevent late sequelae. However, no comparative trials have been adequately conducted to guide the selection of an optimal penicillin regimen (i.e., the dose, duration, and preparation). Substantially fewer data are available for nonpenicillin regimens.

Recommended Regimen for Adults

Benzathine penicillin G 2.4 million units IM in a single dose.

NOTE: Recommendations for treating pregnant women and HIV-infected patients for syphilis are discussed in separate sections.

Recommended Regimen for Children

After the newborn period, children with syphilis should have a CSF examination to detect asymptomatic neurosyphilis, and birth and maternal medical records should be reviewed to assess whether such children have congenital or acquired syphilis (see Congenital Syphilis). Children with acquired primary or secondary syphilis should be evaluated (e.g., through consultation with child-protection services) (see Sexual Assault or Abuse of Children) and treated by using the following pediatric regimen.

Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units in a single dose.

Other Management Considerations

All patients who have syphilis should be tested for HIV infection. In geographic areas in which the prevalence of HIV is high, patients who have primary syphilis should be retested for HIV after 3 months if the first HIV test result was negative.

Patients who have syphilis and who also have symptoms or signs suggesting neurologic disease (e.g., meningitis) or ophthalmic disease (e.g., uveitis) should have an evaluation that includes CSF analysis and ocular slit-lamp examination. Treatment should be guided by the results of this evaluation.

Invasion of CSF by *T. pallidum* accompanied by CSF abnormalities is common among adults who have primary or secondary syphilis. However, neurosyphilis develops in only a limited number of patients after treatment with the penicillin regimens recommended for primary and secondary syphilis. Therefore, unless clinical signs or symptoms of neurologic or ophthalmic involvement are present, CSF analysis is not recommended for routine evaluation of patients who have primary or secondary syphilis.

Follow-Up

Treatment failure can occur with any regimen. However, assessing response to treatment often is difficult, and definitive criteria for cure or failure have not been established. Nontreponemal test titers may decline more slowly for patients who previously had syphilis. Patients should be reexamined clinically and serologically 6 months and 12 months following treatment; more frequent evaluation may be prudent if follow-up is uncertain.

Patients who have signs or symptoms that persist or recur or who have a sustained fourfold increase in nontreponemal test

titer (i.e., compared with the maximum or baseline titer at the time of treatment) probably failed treatment or were reinfected. These patients should be re-treated and reevaluated for HIV infection. Because treatment failure usually cannot be reliably distinguished from reinfection with *T. pallidum*, a CSF analysis also should be performed. A recent clinical trial demonstrated that 15% of patients with early syphilis treated with the recommended therapy will not achieve a two dilution decline in nontreponemal titer used to define response at 1 year following treatment.

Failure of nontreponemal test titers to decline fourfold within 6 months after therapy for primary or secondary syphilis is indicative of probable treatment failure. Persons for whom titers remain serofast should be reevaluated for HIV infection. Optimal management of such patients is unclear. At a minimum, these patients should have additional clinical and serologic follow-up. HIV-infected patients should be evaluated more frequently (i.e., at 3-month intervals instead of 6-month intervals). If additional follow-up cannot be ensured, re-treatment is recommended. Because treatment failure may be the result of unrecognized CNS infection, some specialists recommend CSF examination in such situations.

When patients are re-treated, most STD specialists recommend administering weekly injections of benzathine penicillin G 2.4 million units IM for 3 weeks, unless CSF examination indicates that neurosyphilis is present. In rare instances, serologic titers do not decline despite a negative CSF examination and a repeated course of therapy. Additional therapy or repeated CSF examinations are not warranted in these circumstances.

Management of Sex Partners

See General Principles, Management of Sex Partners.

Special Considerations

Penicillin Allergy. Data to support the use of alternatives to penicillin in the treatment of early syphilis are limited. However, several therapies might be considered effective in nonpregnant, penicillin-allergic patients who have primary or secondary syphilis. Doxycycline (100 mg orally twice daily for 14 days) and tetracycline (500 mg four times daily for 14 days) are regimens that have been used for many years. Compliance is likely to be better with doxycycline than tetracycline, because tetracycline can cause gastrointestinal side effects. Although limited clinical studies, along with biologic and pharmacologic evidence, suggest that ceftriaxone is effective for treating early syphilis, the optimal dose and duration of ceftriaxone therapy have not been defined. However, some specialists recommend 1 gram daily either IM or IV for 8–10 days. Preliminary data suggest that azithromycin may be effective as a single oral dose of 2 grams. Because the efficacy of these therapies is not well documented, close follow-up of persons receiving these therapies is essential. The use of any of these therapies in HIV-infected persons has not been studied; the use of doxycycline, ceftriaxone, and azithromycin among such persons must be undertaken with caution.

Patients with penicillin allergy whose compliance with therapy or follow-up cannot be ensured should be desensitized and treated with benzathine penicillin. Skin testing for penicillin allergy may be useful in some circumstances in which the reagents and expertise are available to perform the test adequately (see Management of Patients Who Have a History of Penicillin Allergy).

Pregnancy. Pregnant patients who are allergic to penicillin should be desensitized and treated with penicillin (see Management of Patients Who Have a History of Penicillin Allergy and Syphilis During Pregnancy).

HIV Infection. See Syphilis Among HIV-Infected Persons.

Latent Syphilis

Latent syphilis is defined as syphilis characterized by seroreactivity without other evidence of disease. Patients who have latent syphilis and who acquired syphilis within the preceding year are classified as having early latent syphilis. Patients can be diagnosed as having early latent syphilis if, within the year preceding the evaluation, they had a) a documented seroconversion, b) unequivocal symptoms of primary or secondary syphilis, or c) a sex partner documented to have primary, secondary, or early latent syphilis. Patients who have latent syphilis of unknown duration should be managed as if they have late latent syphilis. Nontreponemal serologic titers usually are higher during early latent syphilis than late latent syphilis. However, early latent syphilis cannot be reliably distinguished from late latent syphilis solely on the basis of nontreponemal titers. All patients with latent syphilis should have careful examination of all accessible mucosal surfaces (i.e., the oral cavity, the perineum in women, and underneath the foreskin in uncircumcised men) to evaluate for internal mucosal lesions. All patients who have syphilis should be tested for HIV infection.

Treatment

Treatment of latent syphilis usually does not affect transmission and is intended to prevent occurrence or progression of late complications. Although clinical experience supports the effectiveness of penicillin in achieving these goals, limited evidence is available for guidance in choosing specific regimens.

The following regimens are recommended for nonallergic patients who have normal CSF examinations (if performed).

Recommended Regimens for Adults

Early Latent Syphilis

Benzathine penicillin G 2.4 million units IM in a single dose.

Late Latent Syphilis or Latent Syphilis of Unknown Duration

Benzathine penicillin G 7.2 million units total, administered as three doses of 2.4 million units IM each at 1-week intervals.

After the newborn period, children with syphilis should have a CSF examination to exclude neurosyphilis. In addition, birth and maternal medical records should be reviewed to assess whether children have congenital or acquired syphilis (see Congenital Syphilis). Older children with acquired latent syphilis should be evaluated as described for adults and treated using the following pediatric regimens (see Sexual Assault or Abuse of Children). These regimens are for non-allergic children who have acquired syphilis and who have normal CSF examination results.

Recommended Regimens for Children

Early Latent Syphilis

Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units in a single dose.

Late Latent Syphilis or Latent Syphilis of Unknown Duration

Benzathine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units, administered as three doses at 1-week intervals (total 150,000 units/kg up to the adult total dose of 7.2 million units).

Other Management Considerations

All patients who have latent syphilis should be evaluated clinically for evidence of tertiary disease (e.g., aortitis, gumma, and iritis). Patients who have syphilis and who demonstrate any of the following criteria should have a prompt CSF examination:

- neurologic or ophthalmic signs or symptoms;
- evidence of active tertiary syphilis (e.g., aortitis, gumma, and iritis);
- treatment failure; or
- HIV infection with late latent syphilis or syphilis of unknown duration.

If dictated by circumstances and patient preferences, a CSF examination may be performed for patients who do not meet these criteria. Some specialists recommend performing a CSF examination on all patients who have latent syphilis and a nontreponemal serologic test of ≥1:32. The risk of neurosyphilis in this circumstance is unknown. If a CSF examination is performed and the results indicate abnormalities consistent with neurosyphilis, the patient should be treated for neurosyphilis (see Neurosyphilis).

If a patient misses a dose of penicillin in the course of weekly therapy for late syphilis, the appropriate course of action is unclear. Pharmacologic considerations suggest that an interval of 10–14 days between doses of benzathine penicillin for late syphilis or latent syphilis of unknown duration might be acceptable before restarting the sequence of injections. Missed doses should not be considered acceptable for pregnant patients receiving therapy for late latent syphilis; pregnant women who miss any dose of therapy must repeat the full course of therapy.

Follow-Up. Quantitative nontreponemal serologic tests should be repeated at 6, 12, and 24 months. Patients with a normal CSF examination should be re-treated for latent syphilis if a) titers increase fourfold, b) an initially high titer (≥1:32) fails to decline at least fourfold (i.e., two dilutions) within 12–24 months of therapy, or c) signs or symptoms attributable to syphilis develop. In rare instances, despite a negative CSF examination and a repeated course of therapy, serologic titers may still not decline. In these circumstances, the need for additional therapy or repeated CSF examinations is unclear.

Management of Sex Partners. See General Principles, Management of Sex Partners.

Special Considerations

Penicillin Allergy. The effectiveness of alternatives to penicillin in the treatment of latent syphilis has not been well documented. Nonpregnant patients allergic to penicillin who have clearly defined early latent syphilis should respond to therapies recommended as alternatives to penicillin for the treatment of primary and secondary syphilis (see Treatment of Primary and Secondary Syphilis). The only acceptable alternatives for the treatment of late latent syphilis or latent syphilis of unknown duration are doxycycline (100 mg orally twice daily) or tetracycline (500 mg orally four times daily) both for 28 days. These therapies should be used only in conjunction with close serologic and clinical follow-up. The efficacy of these alternative regimens in HIV-infected persons has not been studied, and thus must be considered with caution.

Pregnancy. Pregnant patients who are allergic to penicillin should be desensitized and treated with penicillin (see Management of Patients Who Have a History of Penicillin Allergy and Syphilis During Pregnancy).

HIV Infection. See Syphilis Among HIV-Infected Persons.

Tertiary Syphilis

Tertiary syphilis refers to gumma and cardiovascular syphilis, but not to all neurosyphilis. Patients who are not allergic to penicillin and have no evidence of neurosyphilis should be treated with the following regimen.

Recommended Regimen

Benzathine penicillin G 7.2 million units total, administered as three doses of 2.4 million units IM each at 1-week intervals.

Other Management Considerations

Patients who have symptomatic late syphilis should be given a CSF examination before therapy is initiated. Some providers treat all patients who have cardiovascular syphilis with a neurosyphilis regimen. The complete management of patients who have cardiovascular or gummatous syphilis is beyond the scope of these guidelines. These patients should be managed in consultation with an infectious diseases specialist.

Follow-Up. Limited information is available concerning clinical response and follow-up of patients who have tertiary syphilis.

Management of Sex Partners. See General Principles, Management of Sex Partners.

Special Considerations

Penicillin Allergy. Patients allergic to penicillin should be treated according to treatment regimens recommended for late latent syphilis.

Pregnancy. Pregnant patients who are allergic to penicillin should be desensitized, if necessary, and treated with penicillin (see Management of Patients Who Have a History of Penicillin Allergy and Syphilis During Pregnancy).

HIV Infection. See Syphilis Among HIV-Infected Persons.

Neurosyphilis

Treatment

CNS disease can occur during any stage of syphilis. A patient who has clinical evidence of neurologic involvement with syphilis (e.g., cognitive dysfunction, motor or sensory deficits, ophthalmic or auditory symptoms, cranial nerve palsies, and symptoms or signs of meningitis) should have a CSF examination.

Syphilitic uveitis or other ocular manifestations frequently are associated with neurosyphilis; patients with these symptoms should be treated according to the recommendations for patients with neurosyphilis. A CSF examination should be performed for all such patients to identify those with abnormalities who should have follow-up CSF examinations to assess treatment response.

Patients who have neurosyphilis or syphilitic eye disease (e.g., uveitis, neuroretinitis, and optic neuritis) should be treated with the following regimen.

Recommended Regimen

Aqueous crystalline penicillin G 18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion, for 10–14 days.

If compliance with therapy can be ensured, patients may be treated with the following alternative regimen.

Alternative Regimen

Procaine penicillin 2.4 million units IM once daily

PLUS

Probenecid 500 mg orally four times a day, both for 10–14 days.

The durations of the recommended and alternative regimens for neurosyphilis are shorter than that of the regimen used for late syphilis in the absence of neurosyphilis. Therefore, some specialists administer benzathine penicillin, 2.4 million units IM once per week for up to 3 weeks after completion of these neurosyphilis treatment regimens to provide a comparable total duration of therapy.

Other Management Considerations

Other considerations in the management of patients who have neurosyphilis are as follows.

- All patients who have syphilis should be tested for HIV.
- Many specialists recommend treating patients who have evidence of auditory disease caused by syphilis in the same manner as patients who have neurosyphilis, regardless of CSF examination results. Although systemic steroids are used frequently as adjunctive therapy for otologic syphilis, such drugs have not been proven beneficial.

Follow-Up. If CSF pleocytosis was present initially, a CSF examination should be repeated every 6 months until the cell count is normal. Follow-up CSF examinations also can be used to evaluate changes in the VDRL-CSF or CSF protein after therapy; however, changes in these two parameters are slower, and persistent abnormalities may be less important. If the cell count has not decreased after 6 months, or if the CSF is not normal after 2 years, re-treatment should be considered.

Management of Sex Partners. See General Principles, Management of Sex Partners.

Special Considerations

Penicillin Allergy. Ceftriaxone can be used as an alternative treatment for patients with neurosyphilis, although the possibility of cross-reactivity between this agent and penicillin exists. Some specialists recommend ceftriaxone 2 grams daily

either IM or IV for 10–14 days. Other regimens have not been adequately evaluated for treatment of neurosyphilis. Therefore, if concern exists regarding the safety of ceftriaxone for a patient with neurosyphilis, the patient should obtain skin testing to confirm penicillin allergy and, if necessary, be desensitized and managed in consultation with a specialist.

Pregnancy. Pregnant patients who are allergic to penicillin should be desensitized, if necessary, and treated with penicillin (see Syphilis During Pregnancy).

HIV Infection. See Syphilis Among HIV-Infected Patients.

Syphilis Among HIV-Infected Persons

Diagnostic Considerations

Unusual serologic responses have been observed among HIV-infected persons who have syphilis. Most reports have involved serologic titers that were higher than expected, but false-negative serologic test results and delayed appearance of seroreactivity also have been reported. However, aberrant serologic responses are uncommon, and most specialists believe that both treponemal and non-treponemal serologic tests for syphilis can be interpreted in the usual manner for most patients who are coinfected with *T. pallidum* and HIV.

When clinical findings are suggestive of syphilis, but serologic tests are nonreactive or the interpretation is unclear, alternative tests (e.g., biopsy of a lesion, darkfield examination, or direct fluorescent antibody staining of lesion material) may be useful for diagnosis.

Neurosyphilis should be considered in the differential diagnosis of neurologic disease in HIV-infected persons.

Treatment

Compared with HIV-negative patients, HIV-positive patients who have early syphilis may be at increased risk for neurologic complications and may have higher rates of treatment failure with currently recommended regimens. The magnitude of these risks, although not defined precisely, is likely minimal. No treatment regimens for syphilis have been demonstrated to be more effective in preventing neurosyphilis in HIV-infected patients than the syphilis regimens recommended for HIV-negative patients. Careful follow-up after therapy is essential.

Primary and Secondary Syphilis Among HIV-Infected Persons

Treatment

Treatment with benzathine penicillin G, 2.4 million units IM in a single dose is recommended. Some specialists recommend additional treatments (e.g., benzathine penicillin G administered at 1-week intervals for 3 weeks, as recommended for late syphilis) in addition to benzathine penicillin G 2.4 million units IM.

Other Management Considerations

Because CSF abnormalities (e.g., mononuclear pleocytosis and elevated protein levels) are common in patients with early syphilis and in persons with HIV infection, the clinical and prognostic significance of such CSF abnormalities in HIV-infected persons with primary or secondary syphilis is unknown. Although most HIV-infected persons respond appropriately to standard benzathine penicillin therapy, some specialists recommend intensified therapy when CNS syphilis is suspected in these persons. Therefore, some specialists recommend CSF examination before treatment of HIV-infected persons with early syphilis, with follow-up CSF examination following treatment in persons with initial abnormalities.

Follow-Up. HIV-infected patients should be evaluated clinically and serologically for treatment failure at 3, 6, 9, 12, and 24 months after therapy. Although of unproven benefit, some specialists recommend a CSF examination 6 months after therapy.

HIV-infected patients who meet the criteria for treatment failure should be managed in the same manner as HIV-negative patients (i.e., a CSF examination and re-treatment). CSF examination and re-treatment also should be strongly considered for patients whose nontreponemal test titers do not decrease fourfold within 6–12 months of therapy. Most specialists would re-treat patients with benzathine penicillin G administered as three doses of 2.4 million units IM each at weekly intervals, if CSF examinations are normal.

Special Considerations

Penicillin Allergy. Penicillin-allergic patients who have primary or secondary syphilis and HIV infection should be managed according to the recommendations for penicillin-allergic, HIV-negative patients. The use of alternatives to penicillin has not been well studied in HIV-infected patients.

Latent Syphilis Among HIV-Infected Persons

Diagnostic Considerations

HIV-infected patients who have early latent syphilis should be managed and treated according to the recommendations for HIV-negative patients who have primary and secondary syphilis. HIV-infected patients who have either late latent syphilis or syphilis of unknown duration should have a CSF examination before treatment.

Treatment

Patients with late latent syphilis or syphilis of unknown duration and a normal CSF examination can be treated with benzathine penicillin G, at weekly doses of 2.4 million units for 3 weeks. Patients who have CSF consistent with neurosyphilis should be treated and managed as patients who have neurosyphilis (see Neurosyphilis).

Follow-Up. Patients should be evaluated clinically and serologically at 6, 12, 18, and 24 months after therapy. If, at any time, clinical symptoms develop or nontreponemal titers rise fourfold, a repeat CSF examination should be performed and treatment administered accordingly. If in 12–24 months the nontreponemal titer does not decline fourfold, the CSF examination should be repeated and treatment administered accordingly.

Special Considerations

Penicillin Allergy. Patients with penicillin allergy whose compliance with therapy or follow-up cannot be ensured should be desensitized and treated with penicillin (see Management of Patients Who Have a History of Penicillin Allergy). The efficacy of alternative non-penicillin regimens in HIV-infected persons has not been studied.

Syphilis During Pregnancy

All women should be screened serologically for syphilis at the first prenatal visit. In populations in which prenatal care is not optimal, RPR-card test screening and treatment (if the RPR-card test is reactive) should be performed at the time a pregnancy is confirmed. For communities and populations in which the prevalence of syphilis is high or for patients at high risk, serologic testing should be performed twice during the third trimester, at 28 weeks' gestation, and at delivery in addition to routine early screening. Some states mandate screening at delivery for all women. Any woman who delivers a stillborn infant after 20 weeks' gestation should be tested for syphilis. No infant should leave the hospital if maternal serologic status has not been determined at least once during pregnancy and preferably again at delivery.

Diagnostic Considerations

Seropositive pregnant women should be considered infected unless an adequate treatment history is documented in the medical records and sequential serologic antibody titers have declined.

Treatment

Penicillin is effective for preventing maternal transmission to the fetus and for treating fetal infection. Evidence is insufficient to determine whether the specific, recommended penicillin regimens are optimal.

Recommended Regimen

Treatment during pregnancy should consist of the penicillin regimen appropriate for the stage of syphilis.

Other Management Considerations

Some specialists recommend additional therapy in some patients. A second dose of benzathine penicillin 2.4 million units IM may be administered 1 week after the initial dose for women who have primary, secondary, or early latent syphilis. In the second half of pregnancy, management and counseling may be facilitated by a sonographic fetal evaluation for congenital syphilis, but this should not delay therapy. Sonographic signs of fetal syphilis (i.e., hepatomegaly, ascites, and hydrops) indicate a greater risk for fetal treatment failure; such cases should be managed in consultation with obstetric specialists. Evidence is insufficient to recommend specific regimens for these situations.

Women treated for syphilis during the second half of pregnancy are at risk for premature labor and/or fetal distress if the treatment precipitates the Jarisch-Herxheimer reaction. These women should be advised to seek obstetric attention after treatment if they notice any contractions or decrease in fetal movements. Although stillbirth is a rare complication of treatment, concern about this complication should not delay necessary treatment. All patients who have syphilis should be offered testing for HIV infection.

Follow-Up. Coordinated prenatal care, treatment follow-up, and syphilis case management are important in the management of pregnant women with syphilis. Serologic titers should be repeated in the third trimester and at delivery. Serologic titers may be checked monthly in women at high risk for reinfection or in geographic areas in which the prevalence of syphilis is high. The clinical and antibody response should be appropriate for the stage of disease. Most women will deliver before their serologic response to treatment can be assessed definitively.

Management of Sex Partners. See General Principles, Management of Sex Partners.

Special Considerations

Penicillin Allergy. No alternatives to penicillin have been proved effective for treatment of syphilis during pregnancy. Pregnant women who have a history of penicillin allergy should be desensitized and treated with penicillin. Skin testing may be helpful (see Management of Patients Who Have a History of Penicillin Allergy).

Tetracycline and doxycycline should not used during pregnancy. Erythromycin should not be used, because it does not reliably cure an infected fetus. Data are insufficient to recommend azithromycin or ceftriaxone.

HIV Infection. See Syphilis Among HIV-Infected Patients.

Congenital Syphilis

Effective prevention and detection of congenital syphilis depends on the identification of syphilis in pregnant women and, therefore, on the routine serologic screening of pregnant women during the first prenatal visit. Serologic testing and a sexual history also should be obtained at 28 weeks of gestation and at delivery in communities and populations in which the risk for congenital syphilis is high. Moreover, as part of the management of pregnant women who have syphilis, information concerning treatment of sex partners should be obtained to assess the risk for reinfection. All pregnant women who have syphilis should be tested for HIV infection.

Routine screening of newborn sera or umbilical cord blood is not recommended. Serologic testing of the mother's serum is preferred over testing infant serum, because the serologic tests performed on infant serum can be nonreactive if the mother's serologic test result is of low titer or if the mother was infected late in pregnancy. No infant or mother should leave the hospital unless the maternal serologic status has been documented at least once during pregnancy and preferably again at delivery.

Evaluation and Treatment of Infants in the First Month of Life

The diagnosis of congenital syphilis is complicated by the transplacental transfer of maternal nontreponemal and treponemal immunoglobulin G (IgG) antibodies to the fetus. This transfer of antibodies makes the interpretation of reactive serologic tests for syphilis in infants difficult. Treatment decisions often must be made on the basis of a) identification of syphilis in the mother; b) adequacy of maternal treatment; c) presence of clinical, laboratory, or radiographic evidence of syphilis in the infant; and d) comparison of maternal (at delivery) and infant nontreponemal serologic titers utilizing the same test and preferably the same laboratory.

All infants born to mothers who have reactive nontreponemal and treponemal test results should be evaluated with a quantitative nontreponemal serologic test (RPR or VDRL) performed on infant serum, because umbilical cord blood can become contaminated with maternal blood and could yield a false-positive result. Conducting a treponemal test (i.e., TP-PA or FTA-ABS) on a newborn's serum is not necessary. Currently, no commercially available IgM test can be recommended.

All infants born to women who have reactive serologic tests for syphilis should be examined thoroughly for evidence of congenital syphilis (e.g., nonimmune hydrops, jaundice, hepatosplenomegaly, rhinitis, skin rash, and/or pseudoparalysis of an extremity). Pathologic examination of the placenta or umbilical cord using specific fluorescent antitreponemal antibody staining is suggested. Darkfield microscopic examination or direct fluorescent antibody staining of suspicious lesions or body fluids (e.g., nasal discharge) also should be performed.

The following scenarios describe the evaluation and treatment of infants for congenital syphilis.

Scenario 1. Infants with proven or highly probable disease

a) an abnormal physical examination that is consistent with congenital syphilis;
b) a serum quantitative nontreponemal serologic titer that is fourfold greater than the mother's titer;* or
c) a positive darkfield or fluorescent antibody test of body fluid(s).

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein.†
- Complete blood count (CBC) and differential and platelet count.
- Other tests as clinically indicated (e.g., long-bone radiographs, chest radiograph, liver-function tests, cranial ultrasound, ophthalmologic examination, and auditory brainstem response).

Recommended Regimens

Aqueous crystalline penicillin G 100,000–150,000 units/kg/day, administered as 50,000 units/kg/dose IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days

OR

Procaine penicillin G 50,000 units/kg/dose IM in a single daily dose for 10 days.

If more than 1 day of therapy is missed, the entire course should be restarted. Data are insufficient regarding the use of other antimicrobial agents (e.g., ampicillin). When possible, a full 10-day course of penicillin is preferred, even if ampicillin was initially provided for possible sepsis. The use of agents other than penicillin requires close serologic follow-up to assess adequacy of therapy. In all other situations, the

* The absence of a fourfold or greater titer for an infant does not exclude congenital syphilis.

† CSF test results obtained during the neonatal period can be difficult to interpret; normal values differ by gestational age and are higher in preterm infants. Values as high as 25 white blood cells (WBCs)/mm^3 and/or protein of 150 mg/dL might occur among normal neonates; some specialists, however, recommend that lower values (i.e., 5 WBCs/mm^3 and protein of 40 mg/dL) be considered the upper limits of normal. Other causes of elevated values also should be considered when an infant is being evaluated for congenital syphilis.

maternal history of infection with *T. pallidum* and treatment for syphilis must be considered when evaluating and treating the infant.

Scenario 2. Infants who have a normal physical examination and a serum quantitative nontreponemal serologic titer the same or less than fourfold the maternal titer and the

a) mother was not treated, inadequately treated, or has no documentation of having received treatment;
b) mother was treated with erythromycin or other nonpenicillin regimen[§];
c) mother received treatment ≤4 weeks before delivery; or
d) mother has early syphilis and has a nontreponemal titer that has either not decreased fourfold or has increased fourfold.

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein.
- CBC and differential and platelet count.
- Long-bone radiographs.

A complete evaluation is not necessary if 10 days of parenteral therapy is administered. However, such evaluation may be useful; a lumbar puncture may document CSF abnormalities that would prompt close follow-up. Other tests (e.g., CBC, platelet count, and bone radiographs) may be performed to further support a diagnosis of congenital syphilis. If a single dose of benzathine penicillin G is used, then the infant must be fully evaluated (i.e., through CSF examination, long-bone radiographs, and CBC with platelets), the full evaluation must be normal, and follow-up must be certain. If any part of the infant's evaluation is abnormal or not performed, or if the CSF analysis is rendered uninterpretable because of contamination with blood, then a 10-day course of penicillin is required.[¶]

Recommended Regimens

Aqueous crystalline penicillin G 100,000–150,000 units/kg/day, administered as 50,000 units/kg/dose IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days,

OR

Procaine penicillin G 50,000 units/kg/dose IM in a single daily dose for 10 days,

OR

Benzathine penicillin G 50,000 units/kg/dose IM in a single dose.

NOTE: Some specialists prefer the 10 days of parenteral therapy if the mother has untreated early syphilis at delivery.

Scenario 3. Infants who have a normal physical examination and a serum quantitative nontreponemal serologic titer the same or less than fourfold the maternal titer and the

a) mother was treated during pregnancy, treatment was appropriate for the stage of infection, and treatment was administered >4 weeks before delivery;
b) mother's nontreponemal titers decreased fourfold after appropriate therapy for early syphilis or remained stable and low for late syphilis; and
c) mother has no evidence of reinfection or relapse.

Recommended Evaluation

No evaluation is required.

Recommended Regimen

Benzathine penicillin G 50,000 units/kg/dose IM in a single dose.**

Scenario 4. Infants who have a normal physical examination and a serum quantitative nontreponemal serologic titer the same or less than fourfold the maternal titer and the

a) mother's treatment was adequate before pregnancy and
b) mother's nontreponemal serologic titer remained low and stable before and during pregnancy and at delivery (VDRL ≤1:2; RPR ≤1:4).

Recommended Evaluation

No evaluation is required.

Recommended Regimen

No treatment is required; however, some specialists would treat with benzathine penicillin G 50,000 units/kg as a single IM injection, particularly if follow-up is uncertain.

[§] A woman treated with a regimen other than those recommended in these guidelines for treatment should be considered untreated.

[¶] If the infant's nontreponemal test is nonreactive and the likelihood of the infant being infected is low, some specialists recommend no evaluation but treatment of the infant with a single IM dose of benzathine penicillin G 50,000 units/kg for possible incubating syphilis, after which the infant should receive close serologic follow-up.

**Some specialists would not treat the infant but would provide close serologic follow-up.

Evaluation and Treatment of Older Infants and Children

Children who are identified as having reactive serologic tests for syphilis after the neonatal period (i.e., at >1 month of age) should have maternal serology and records reviewed to assess whether the child has congenital or acquired syphilis (for acquired syphilis, see Primary and Secondary Syphilis and Latent Syphilis). Any child at risk for congenital syphilis should receive a full evaluation and testing for HIV infection.

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein.
- Complete blood count (CBC), differential, and platelet count.
- Other tests as clinically indicated (e.g., long-bone radiographs, chest radiograph, liver function tests, abdominal ultrasound, ophthalmologic examination, and auditory brain stem response).

Recommended Regimens

Aqueous crystalline penicillin G 200,000–300,000 units/kg/day IV, administered as 50,000 units/kg every 4–6 hours for 10 days.

Any child who is suspected of having congenital syphilis or who has neurologic involvement should be treated with aqueous penicillin G. Some specialists also suggest giving these patients a single dose of benzathine penicillin G, 50,000 units/kg IM following the 10-day course of IV aqueous penicillin.

Follow-Up

All seroreactive infants (or infants whose mothers were seroreactive at delivery) should receive careful follow-up examinations and serologic testing (i.e., a nontreponemal test) every 2–3 months until the test becomes nonreactive or the titer has decreased fourfold. Nontreponemal antibody titers should decline by 3 months of age and should be nonreactive by 6 months of age if the infant was not infected (i.e., if the reactive test result was caused by passive transfer of maternal IgG antibody) or was infected but adequately treated. The serologic response after therapy may be slower for infants treated after the neonatal period. If these titers are stable or increase after 6–12 months of age, the child should be evaluated (e.g., given a CSF examination) and treated with a 10-day course of parenteral penicillin G.

Treponemal tests should not be used to evaluate treatment response because the results for an infected child can remain positive despite effective therapy. Passively transferred maternal treponemal antibodies can be present in an infant until age 15 months. A reactive treponemal test after age 18 months is diagnostic of congenital syphilis. If the nontreponemal test is nonreactive at this time, no further evaluation or treatment is necessary. If the nontreponemal test is reactive at age 18 months, the infant should be fully (re)evaluated and treated for congenital syphilis.

Infants whose initial CSF evaluations are abnormal should undergo a repeat lumbar puncture approximately every 6 months until the results are normal. A reactive CSF VDRL test or abnormal CSF indices that cannot be attributed to other ongoing illness requires re-treatment for possible neurosyphilis.

Follow-up of children treated for congenital syphilis after the newborn period should be conducted as is recommended for neonates.

Special Considerations

Penicillin Allergy

Infants and children who require treatment for syphilis but who have a history of penicillin allergy or develop an allergic reaction presumed secondary to penicillin should be desensitized, if necessary, and then treated with penicillin (see Management of Patients With a History of Penicillin Allergy). Data are insufficient regarding the use of other antimicrobial agents (e.g., ceftriaxone); if a nonpenicillin agent is used, close serologic and CSF follow-up are indicated.

HIV Infection

Data are insufficient regarding whether infants who have congenital syphilis and whose mothers are coinfected with HIV require different evaluation, therapy, or follow-up for syphilis than is recommended for all infants.

Management of Patients Who Have a History of Penicillin Allergy

No proven alternatives to penicillin are available for treating neurosyphilis, congenital syphilis, or syphilis in pregnant women. Penicillin is also recommended for use, whenever possible, in HIV-infected patients. Of the adult U.S. population, 3%–10% have experienced urticaria, angioedema, or anaphylaxis (i.e., upper airway obstruction, bronchospasm, or hypotension) after penicillin therapy. Re-administration of penicillin to these patients can cause severe, immediate reactions. Because anaphylactic reactions to penicillin can be fatal, every effort should be made to avoid administering penicillin to penicillin-allergic patients, unless they undergo acute desensitization to eliminate anaphylactic sensitivity.

An estimated 10% of persons who report a history of severe allergic reactions to penicillin remain allergic. With the passage of time after an allergic reaction to penicillin, most

persons who have had a severe reaction stop expressing penicillin-specific immunoglobulin E (IgE). These persons can be treated safely with penicillin. The results of many investigations indicate that skin testing with the major and minor determinants can reliably identify persons at high risk for penicillin reactions. Although these reagents are easily generated and have been available for >30 years, only benzylpenicilloyl poly-L-lysine (Pre-Pen® [i.e., the major determinant]) and penicillin G are available commercially. Testing with only the major determinant and penicillin G identifies an estimated 90%–97% of the currently allergic patients. However, because skin testing without the minor determinants would still miss 3%–10% of allergic patients and because serious or fatal reactions can occur among these minor-determinant-positive patients, specialists suggest exercising caution when the full battery of skin-test reagents is not available (Box 1).

Recommendations

If the full battery of skin-test reagents is available, including the major and minor determinants (see Penicillin Allergy Skin Testing), patients who report a history of penicillin reaction and are skin-test negative can receive conventional penicillin therapy. Skin-test-positive patients should be desensitized.

If the full battery of skin-test reagents, including the minor determinants, is not available, the patient should be skin tested using benzylpenicilloyl poly-L-lysine (i.e., the major determinant) and penicillin G. Patients who have positive test results should be desensitized. Some specialists suggest that persons who have negative test results should be regarded as probably allergic and should be desensitized. Others suggest that those with negative skin-test results can be test-dosed gradually with oral penicillin in a monitored setting in which treatment for anaphylactic reaction can be provided.

Box 1. Skin-test reagents for identifying persons at risk for adverse reactions to penicillin*

Major Determinant

- Benzylpenicilloyl poly-L-lysine (Pre-Pen® [Taylor Pharmacal Company, Decatur, Illinois]) (6×10^{-5}M).

Minor Determinant Precursors†

- Benzylpenicillin G (10^{-2}M, 3.3 mg/mL, 6,000 units/mL),
- Benzylpenicilloate (10^{-2}M, 3.3 mg/mL),
- Benzylpenicilloate (or penicilloyl propylamine) (10^{-2}M, 3.3 mg/mL).

Positive Control

- Commercial histamine for epicutaneous skin testing (1 mg/mL).

Negative Control

- Diluent used to dissolve other reagents, usually phenol saline.

* Adapted from Saxon A, Beall GN, Rohr AS, Adelman DC. Immediate hypersensitivity reactions to beta-lactam antibiotics. Ann Intern Med 1987;107:204–15. Reprinted with permission from G.N. Beall and *Annals of Internal Medicine*.

† Aged penicillin is not an adequate source of minor determinants. Penicillin G should be freshly prepared or should come from a fresh-frozen source.

Penicillin Allergy Skin Testing

Patients at high risk for anaphylaxis, including those who a) have a history of penicillin-related anaphylaxis, asthma, or other diseases that would make anaphylaxis more dangerous and b) are being treated with beta-adrenergic blocking agents, should be tested with 100-fold dilutions of the full-strength skin-test reagents before being tested with full-strength reagents. In these situations, patients should be tested in a monitored setting in which treatment for an anaphylactic reaction is available. If possible, the patient should not have taken antihistamines recently (e.g., chlorpheniramine maleate or terfenadine during the preceding 24 hours, diphenhydramine HCl or hydroxyzine during the preceding 4 days, or astemizole during the preceding 3 weeks).

Procedures

Dilute the antigens either a) 100-fold for preliminary testing if the patient has had a life-threatening reaction to penicillin or b) 10-fold if the patient has had another type of immediate, generalized reaction to penicillin within the preceding year.

Epicutaneous (Prick) Tests

Duplicate drops of skin-test reagent are placed on the volar surface of the forearm. The underlying epidermis is pierced with a 26-gauge needle without drawing blood.

An epicutaneous test is positive if the average wheal diameter after 15 minutes is 4 mm larger than that of negative controls; otherwise, the test is negative. The histamine controls should be positive to ensure that results are not falsely negative because of the effect of antihistaminic drugs.

Intradermal Test

If epicutaneous tests are negative, duplicate 0.02 mL intradermal injections of negative control and antigen solutions are made into the volar surface of the forearm using a 26- or 27-gauge needle on a syringe. The crossed diameters of the wheals induced by the injections should be recorded.

An intradermal test is positive if the average wheal diameter 15 minutes after injection is ≥2 mm larger than the initial wheal size and also is ≥2 mm larger than the negative controls. Otherwise, the tests are negative.

Desensitization

Patients who have a positive skin test to one of the penicillin determinants can be desensitized (Table 1). This is a straightforward, relatively safe procedure that can be done orally or IV. Although the two approaches have not been compared, oral desensitization is regarded as safer to use and easier to perform. Patients should be desensitized in a hospital setting because serious IgE-mediated allergic reactions rarely can occur. Desensitization usually can be completed in approximately 4 hours, after which the first dose of penicillin is administered. After desensitization, patients must be maintained on penicillin continuously for the duration of the course of therapy.

Diseases Characterized by Urethritis and Cervicitis

Management of Male Patients Who Have Urethritis

Urethritis is caused by an infection characterized by urethral discharge of mucopurulent or purulent material and sometimes by dysuria or urethral pruritis. Asymptomatic infections are common. The principal bacterial pathogens of proven clinical importance in men who have urethritis are *N. gonorrhoeae* and *C. trachomatis*. Testing to determine the specific etiology is recommended because both chlamydia and gonorrhea are conditions that are reportable to state health departments, and a specific diagnosis may enhance partner notification and improve compliance with treatment, especially in the exposed partner. If diagnostic tools (e.g., a Gram stain and microscope) are unavailable, patients should be treated for both infections. The additional antibiotic exposure and expense of treating a person who has nongonococcal urethritis (NGU) for both infections also should encourage the health-care provider to make a specific diagnosis. Nucleic acid amplification tests enable detection of *N. gonorrhoeae* and *C. trachomatis* on all specimens. These tests are more sensitive than traditional culture techniques for *C. trachomatis* and are the preferred method for the detection of this organism.

TABLE 1. Oral desensitization protocol for patients with a positive skin test*

Penicillin V suspension dose†	Amount§ (units/mL)	mL	Units	Cumulative dose (units)
1	1,000	0.1	100	100
2	1,000	0.2	200	300
3	1,000	0.4	400	700
4	1,000	0.8	800	1,500
5	1,000	1.6	1,600	3,100
6	1,000	3.2	3,200	6,300
7	1,000	6.4	6,400	12,700
8	10,000	1.2	12,000	24,700
9	10,000	2.4	24,000	48,700
10	10,000	4.8	48,000	96,700
11	80,000	1.0	80,000	176,700
12	80,000	2.0	160,000	336,700
13	80,000	4.0	320,000	656,700
14	80,000	8.0	640,000	1,296,700

NOTE: Observation period: 30 minutes before parenteral administration of penicillin.

* Reprinted with permission from the *New England Journal of Medicine* (Wendel GO, Jr, Stark BJ, Jamison RB, Melina RD, Sullivan TJ. Penicillin allergy and desensitization in serious infections during pregnancy. N Engl J Med 1985;312:1229–32.).

† Interval between doses, 15 minutes; elapsed time, 3 hours and 45 minutes; cumulative dose, 1.3 million units.

§ The specific amount of drug was diluted in approximately 30 mL of water and then administered orally.

Etiology

NGU is diagnosed if Gram-negative intracellular diplococci cannot be identified on urethral smears. *C. trachomatis* is a frequent cause (i.e., 15%–55% of cases); however, the prevalence differs by age group, with lower prevalence of this organism among older men. The proportion of NGU cases caused by chlamydia has been declining gradually. Complications of NGU among men infected with *C. trachomatis* include epididymitis and Reiter's syndrome. Documentation of chlamydia infection is important because of the need for partner referral for evaluation and treatment.

The etiology of most cases of nonchlamydial NGU is unknown. *Ureaplasma urealyticum* and *Mycoplasma genitalium* have been implicated as causes of NGU in some studies. Specific diagnostic tests for these organisms are not indicated, because the detection of these organisms is often difficult and would not alter therapy.

T. vaginalis and HSV sometimes cause NGU. Diagnostic and treatment procedures for these organisms are reserved for situations in which these infections are suspected (e.g., contact with trichomoniasis and genital lesions suggestive of genital herpes) or when NGU is not responsive to therapy.

Confirmed Urethritis

Clinicians should document that urethritis is present. Urethritis can be documented on the basis of any of the following signs.

- Mucopurulent or purulent discharge.
- Gram stain of urethral secretions demonstrating ≥5 WBCs per oil immersion field. The Gram stain is the preferred

rapid diagnostic test for evaluating urethritis. It is highly sensitive and specific for documenting both urethritis and the presence or absence of gonococcal infection. Gonococcal infection is established by documenting the presence of WBCs containing intracellular Gram-negative diplococci.

- Positive leukocyte esterase test on first-void urine or microscopic examination of first-void urine demonstrating ≥10 WBCs per high power field.

If none of these criteria is present, then treatment should be deferred, and the patient should be tested for *N. gonorrhoeae* and *C. trachomatis* and followed closely if test results are negative. If the results demonstrate infection with either *N. gonorrhoeae* or *C. trachomatis*, the appropriate treatment should be given and sex partners referred for evaluation and treatment.

Empiric treatment of symptoms without documentation of urethritis is recommended only for patients at high risk for infection who are unlikely to return for a follow-up evaluation. Such patients should be treated for gonorrhea and chlamydia. Partners of patients treated empirically should be evaluated and treated.

Management of Patients Who Have Nongonococcal Urethritis

Diagnosis

All patients who have urethritis should be evaluated for the presence of gonococcal and chlamydial infection. Testing for chlamydia is strongly recommended because of the increased utility and availability of highly sensitive and specific testing methods, and because a specific diagnosis may enhance partner notification and improve compliance with treatment, especially in the exposed partner.

Treatment

Treatment should be initiated as soon as possible after diagnosis. Single-dose regimens have the advantage of improved compliance and of DOT. To improve compliance, the medication should be provided in the clinic or health-care provider's office.

Recommended Regimens

Azithromycin 1 g orally in a single dose

OR

Doxycycline 100 mg orally twice a day for 7 days.

Alternative Regimens

Erythromycin base 500 mg orally four times a day for 7 days,

OR

Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days,

OR

Ofloxacin 300 mg twice a day for 7 days,

OR

Levofloxacin 500 mg once daily for 7 days.

Follow-Up for Patients Who Have Urethritis

Patients should be instructed to return for evaluation if symptoms persist or recur after completion of therapy. Symptoms alone, without documentation of signs or laboratory evidence of urethral inflammation, are not a sufficient basis for re-treatment. Patients should be instructed to abstain from sexual intercourse until 7 days after therapy is initiated.

Partner Referral

Patients should refer for evaluation and treatment all sex partners within the preceding 60 days. Because a specific diagnosis may facilitate partner referral, testing for gonorrhea and chlamydia is encouraged.

Recurrent and Persistent Urethritis

Objective signs of urethritis should be present before initiation of antimicrobial therapy. Effective regimens have not been identified for treating patients who do not have objective signs of urethritis but who have persistent symptoms after treatment. Patients who have persistent or recurrent urethritis should be re-treated with the initial regimen if they did not comply with the treatment regimen or if they were reexposed to an untreated sex partner. Otherwise, a culture of an intraurethral swab specimen and a first-void urine specimen for *T. vaginalis* should be performed. Some cases of recurrent urethritis following doxycycline treatment may be caused by tetracycline-resistant *U. urealyticum*. Urologic examinations usually do not reveal a specific etiology. If the patient was compliant with the initial regimen and re-exposure can be excluded, the following regimen is recommended.

Recommended Regimens

Metronidazole 2 g orally in a single dose

PLUS

Erythromycin base 500 mg orally four times a day for 7 days

OR

Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days.

Special Considerations

HIV Infection

Gonococcal urethritis, chlamydial urethritis, and nongoncoccal, nonchlamydial urethritis may facilitate HIV transmission. Patients who have NGU and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Management of Patients Who Have Mucopurulent Cervicitis (MPC)

MPC is characterized by a purulent or mucopurulent endocervical exudate visible in the endocervical canal or in an endocervical swab specimen. Some specialists also diagnose MPC on the basis of easily induced cervical bleeding. Although some specialists consider an increased number of polymorphonuclear leukocytes on endocervical Gram stain as being useful in the diagnosis of MPC, this criterion has not been standardized, has a low positive-predictive value (PPV), and is not available in some settings. MPC often is asymptomatic, but some women have an abnormal vaginal discharge and vaginal bleeding (e.g., after sexual intercourse). MPC can be caused by *C. trachomatis* or *N. gonorrhoeae*; however, in most cases neither organism can be isolated. MPC can persist despite repeated courses of antimicrobial therapy. Because relapse or reinfection with *C. trachomatis* or *N. gonorrhoeae* usually does not occur in persons with persistent cases of MPC, other nonmicrobiologic determinants (e.g., inflammation in the zone of ectopy) might be involved.

Patients who have MPC should be tested for *C. trachomatis* and for *N. gonorrhoeae* with the most sensitive and specific test available. However, MPC is not a sensitive predictor of infection with these organisms; most women who have *C. trachomatis* or *N. gonorrhoeae* do not have MPC.

Treatment

The results of sensitive tests for *C. trachomatis* or *N. gonorrhoeae* (e.g., culture or nucleic acid amplification tests) should determine the need for treatment, unless the likelihood of infection with either organism is high or the patient is unlikely to return for treatment. Empiric treatment should be considered for a patient who is suspected of having gonorrhea and/or chlamydia if a) the prevalences of these infections are high in the patient population and b) the patient might be difficult to locate for treatment. If relapse and reinfection have been excluded, management options of persistent MPC are undefined. For such persons, additional antimicrobial therapy may be of minimal benefit.

Follow-Up

Follow-up should be conducted as recommended for the infections for which a woman is being treated. If symptoms persist, women should be instructed to return for reevaluation and to abstain from sexual intercourse, even if they have completed the prescribed therapy.

Management of Sex Partners

Management of sex partners of women treated for MPC should be appropriate for the identified or suspected STD. Partners should be notified, examined, and treated for the STD identified or suspected in the index patient.

Because a microbiologic test of cure usually is not recommended, patients and their sex partners should abstain from sexual intercourse until therapy is completed (i.e., 7 days after a single-dose regimen or after completion of a 7-day regimen).

Special Considerations

HIV Infection

Patients who have MPC and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Chlamydial Infections

In the United States, chlamydial genital infection occurs frequently among sexually active adolescents and young adults. Asymptomatic infection is common among both men and women. Sexually active adolescent women should be screened for chlamydial infection at least annually, even if symptoms are not present. Annual screening of all sexually active women aged 20–25 years is also recommended, as is screening of older women with risk factors (e.g., those who have a new sex partner and those with multiple sex partners). An appropriate sexual risk assessment should always be conducted and may indicate more frequent screening for some women.

Chlamydial Infections in Adolescents and Adults

Several important sequelae can result from *C. trachomatis* infection in women; the most serious of these include pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Some women who have apparently uncomplicated cervical infection already have subclinical upper-reproductive–tract infection. A recent investigation of patients in a health maintenance organization demonstrated that screening and treatment of cervical infection can reduce the likelihood of PID.

Treatment

Treating infected patients prevents transmission to sex partners. In addition, treatment of chlamydia in pregnant women usually prevents transmission of *C. trachomatis* to infants during birth. Treatment of sex partners helps to prevent reinfection of the index patient and infection of other partners.

Coinfection with *C. trachomatis* often occurs among patients who have gonococcal infection; therefore, presumptive treatment of such patients for chlamydia is appropriate (see Gonococcal Infection, Dual Therapy for Gonococcal and Chlamydial Infections). The following recommended treatment regimens and alternative regimens cure infection and usually relieve symptoms.

Recommended Regimens

Azithromycin 1 g orally in a single dose

OR

Doxycycline 100 mg orally twice a day for 7 days.

Alternative Regimens

Erythromycin base 500 mg orally four times a day for 7 days,

OR

Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days,

OR

Ofloxacin 300 mg orally twice a day for 7 days,

OR

Levofloxacin 500 mg orally for 7 days.

The results of clinical trials indicate that azithromycin and doxycycline are equally efficacious (*46,47*). These investigations were conducted primarily in populations in which follow-up was encouraged and adherence to a 7-day regimen was good. Azithromycin should always be available to health-care providers to treat patients for whom compliance is in question.

In populations that have erratic health-care-seeking behavior, poor compliance with treatment, or unpredictable follow-up, azithromycin may be more cost-effective because it enables the provision of single-dose DOT. Doxycycline costs less than azithromycin, and it has been used extensively for a longer period. Erythromycin is less efficacious than either azithromycin or doxycycline, and gastrointestinal side effects frequently discourage patients from complying with this regimen. Ofloxacin is similar in efficacy to doxycycline and azithromycin, but it is more expensive to use and offers no advantage with regard to the dosage regimen. Levofloxacin has not been evaluated for treatment of *C. trachomatis* infection in clinical trials, but because its pharmacology and in vitro microbiologic activity are similar to that of ofloxacin, levofloxacin may be substituted in doses of 500 mg once a day for 7 days. Other quinolones either are not reliably effective against chlamydial infection or have not been adequately evaluated.

To maximize compliance with recommended therapies, medications for chlamydial infections should be dispensed on site, and the first dose should be directly observed. To minimize further transmission of infection, patients treated for chlamydia should be instructed to abstain from sexual intercourse for 7 days after single-dose therapy or until completion of a 7-day regimen. To minimize the risk for reinfection, patients also should be instructed to abstain from sexual intercourse until all of their sex partners are treated.

Follow-Up

Patients do not need to be retested for chlamydia after completing treatment with doxycycline or azithromycin unless symptoms persist or reinfection is suspected. A test of cure may be considered 3 weeks after completion of treatment with erythromycin. The validity of chlamydial culture testing at <3 weeks after completion of therapy to identify patients who did not respond to therapy has not been established. False-negative results can occur resulting from infections involving small numbers of chlamydial organisms. In addition, nonculture tests conducted at <3 weeks after completion of therapy for patients who were treated successfully could yield false-positive results because of continued excretion of dead organisms.

A high prevalence of *C. trachomatis* infection is found in women who have had chlamydial infection in the preceding several months. Most post-treatment infections result from reinfection, often occurring because patient's sex partners were not treated or because the patient resumed sex among a network of persons with a high prevalence of infection. Repeat infection confers an elevated risk of PID and other complications when compared with initial infection. Therefore, recently infected women are a high priority for repeat testing for *C. trachomatis*. For these reasons, clinicians and health-care agencies should consider advising all women with chlamydial infection to be rescreened 3–4 months after treatment. Some specialists believe rescreening is an especially high priority for adolescents. Providers are also strongly encouraged to rescreen all women treated for chlamydial infection whenever they next present for care within the following 12 months, regardless of whether the patient believes that her sex partners were treated.

Rescreening is distinct from early retesting to detect therapeutic failure (test-of-cure). Except in pregnant women, test-of-cure is not recommended for persons treated with the recommended regimens, unless therapeutic compliance is in question.

Management of Sex Partners

Patients should be instructed to refer their sex partners for evaluation, testing, and treatment. The following recommendations on exposure intervals are based on limited evaluation. Sex partners should be evaluated, tested, and treated if they had sexual contact with the patient during the 60 days preceding onset of symptoms in the patient or diagnosis of chlamydia. The most recent sex partner should be evaluated and treated even if the time of the last sexual contact was >60 days before symptom onset or diagnosis.

Patients should be instructed to abstain from sexual intercourse until they and their sex partners have completed treatment. Abstinence should be continued until 7 days after a single-dose regimen or after completion of a 7-day regimen. Timely treatment of sex partners is essential for decreasing the risk for reinfecting the index patient.

Special Considerations

Pregnancy. Doxycycline and ofloxacin are contraindicated in pregnant women. However, clinical experience and preliminary data suggest that azithromycin is safe and effective (*48,49*). Repeat testing (preferably by culture) 3 weeks after completion of therapy with the following regimens is recommended for all pregnant women, because these regimens may not be highly efficacious and the frequent side effects of erythromycin might discourage patient compliance with this regimen.

Recommended Regimens

Erythromycin base 500 mg orally four times a day for 7 days

OR

Amoxicillin 500 mg orally three times daily for 7 days.

Alternative Regimens

Erythromycin base 250 mg orally four times a day for 14 days,

OR

Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days,

OR

Erythromycin ethylsuccinate 400 mg orally four times a day for 14 days,

OR

Azithromycin 1 g orally, single dose.

NOTE: Erythromycin estolate is contraindicated during pregnancy because of drug-related hepatotoxicity.

HIV Infection. Patients who have chlamydial infection and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Chlamydial Infections Among Infants

Prenatal screening of pregnant women can prevent chlamydial infection among neonates. Pregnant women aged <25 years are at high risk for infection. Local or regional prevalence surveys of chlamydial infection can be conducted to confirm the validity of using these recommendations in particular settings.

C. trachomatis infection of neonates results from perinatal exposure to the mother's infected cervix. The prevalence of *C. trachomatis* infection among pregnant women does not vary by race/ethnicity or socioeconomic status. Neonatal ocular prophylaxis with silver nitrate solution or antibiotic ointments does not prevent perinatal transmission of *C. trachomatis* from mother to infant. However, ocular prophylaxis with those agents does prevent gonococcal ophthalmia and therefore should be continued (see Prevention of Ophthalmia Neonatorum).

Initial *C. trachomatis* perinatal infection involves mucous membranes of the eye, oropharynx, urogenital tract, and rectum. *C. trachomatis* infection in neonates is most often recognized by conjunctivitis that develops 5–12 days after birth. Chlamydia is the most frequent identifiable infectious cause of ophthalmia neonatorum. *C. trachomatis* also is a common cause of subacute, afebrile pneumonia with onset from 1–3 months of age. Asymptomatic infections also can occur in the oropharynx, genital tract, and rectum of neonates.

Ophthalmia Neonatorum Caused by *C. trachomatis*

A chlamydial etiology should be considered for all infants aged ≤30 days who have conjunctivitis.

Diagnostic Considerations

Sensitive and specific methods used to diagnose chlamydial ophthalmia in the neonate include both tissue culture and nonculture tests (e.g., direct fluorescent antibody tests, enzyme immunoassays, and nucleic acid amplification tests). Specimens must contain conjunctival cells, not exudate alone. Specimens for culture isolation and nonculture tests should be obtained from the everted eyelid using a dacron-tipped swab or the swab specified by the manufacturer's test kit. A specific diagnosis of *C. trachomatis* infection confirms the need for treatment not only for the neonate, but also for the mother and her sex partner(s). Ocular exudate from infants being evaluated for chlamydial conjunctivitis should also be tested for *N. gonorrhoeae*.

Recommended Regimen

Erythromycin base or **ethylsuccinate** 50 mg/kg/day orally divided into four doses daily for 14 days.[††]

Topical antibiotic therapy alone is inadequate for treatment of chlamydial infection and is unnecessary when systemic treatment is administered.

Follow-Up

The efficacy of erythromycin treatment is approximately 80%; a second course of therapy may be required, and follow-up of infants to determine whether treatment was effective is recommended. The possibility of concomitant chlamydial pneumonia should be considered.

Management of Mothers and Their Sex Partners

The mothers of infants who have chlamydial infection and the sex partners of these women should be evaluated and treated (see Chlamydial Infection in Adolescents and Adults).

Infant Pneumonia Caused by *C. trachomatis*

Characteristic signs of chlamydial pneumonia in infants include a) a repetitive staccato cough with tachypnea and b) hyperinflation and bilateral diffuse infiltrates on a chest radiograph. Wheezing is rare, and infants are typically afebrile. Peripheral eosinophilia sometimes occurs in infants who have chlamydial pneumonia. Because clinical presentations differ, initial treatment and diagnostic tests should encompass *C. trachomatis* for all infants aged 1–3 months who possibly have pneumonia.

Diagnostic Considerations

Specimens for chlamydial testing should be collected from the nasopharynx. Tissue culture is the definitive standard for chlamydial pneumonia. Nonculture tests (e.g., EIA, direct flourescent antibody [DFA], and nucleic acid amplification [NAATs]) can be used, although nonculture tests of nasopharyngeal specimens produce lower sensitivity and specificity than nonculture tests of ocular specimens. Tracheal aspirates and lung biopsy specimens, if collected, should be tested for *C. trachomatis*.

Because of the delay in obtaining test results for chlamydia, the decision to include an agent in the antibiotic regimen that is active against *C. trachomatis* must frequently be based on clinical and radiologic findings. The results of tests for chlamydial infection assist in the management of an infant's illness and determine the need for treating the mother and her sex partner(s).

Recommended Regimen

Erythromycin base or ethylsuccinate 50 mg/kg/day orally divided into four doses daily for 14 days.

Follow-Up

The effectiveness of erythromycin in treating pneumonia caused by *C. trachomatis* is approximately 80%; a second course of therapy may be required. Follow-up of infants is recommended to determine whether the pneumonia has resolved. Some infants with chlamydial pneumonia have abnormal pulmonary function tests later in childhood.

Management of Mothers and Their Sex Partners

Mothers of infants who have chlamydial infection and the sex partners of these women should be evaluated and treated according to the recommended treatment of adults for chlamydial infections (see Chlamydial Infection in Adolescents and Adults).

Infants Born to Mothers Who Have Chlamydial Infection

Infants born to mothers who have untreated chlamydia are at high risk for infection; however, prophylatic antibiotic treatment is not indicated, and the efficacy of such treatment is unknown. Infants should be monitored to ensure appropriate treatment if infection develops.

Chlamydial Infections Among Children

Sexual abuse must be considered a cause of chlamydial infection in preadolescent children, although perinatally transmitted *C. trachomatis* infection of the nasopharynx, urogenital tract, and rectum may persist for >1 year (see Sexual Assault or Abuse of Children).

Diagnostic Considerations

Nonculture tests for chlamydia (e.g., non-amplified probes [EIA and DFA]) should not be used because of the possibility of false-positive test results. With respiratory tract specimens, false-positive results can occur because of cross-reaction of test reagents with *Chlamydia pneumoniae*; with genital and anal specimens, false-positive results occur because of cross-reaction with fecal flora.

[††] An association between oral erythromycin and infantile hypertrophic pyloric stenosis (IHPS) has been reported in infants aged <6 weeks who were treated with this drug. Infants treated with erythromycin should be followed for signs and symptoms of IHPS. Data on use of other macrolides (e.g., azithromycin and clarithromycin) for the treatment of neonatal chlamydia infection are limited. The results of one study involving a limited number of patients suggests that a short course of azithromycin, 20 mg/kg/day orally, one dose daily for 3 days, may be effective.

Recommended Regimens

Children who weigh ≤45 kg:

Erythromycin base or ethylsuccinate 50 mg/kg/day orally divided into four doses daily for 14 days.

Children who weigh ≥45 kg but who are aged <8 years:

Azithromycin 1 g orally in a single dose.

Children aged ≥8 years:

Azithromycin 1 g orally in a single dose

OR

Doxycycline 100 mg orally twice a day for 7 days.

Other Management Considerations

See Sexual Assault or Abuse of Children

Follow-Up. Follow-up cultures are necessary to ensure that treatment has been effective.

Gonococcal Infections

Gonococcal Infections in Adolescents and Adults

In the United States, an estimated 600,000 new *N. gonorrhoeae* infections occur each year. Most infections among men produce symptoms that cause them to seek curative treatment soon enough to prevent serious sequelae, but this may not be soon enough to prevent transmission to others. Among women, many infections do not produce recognizable symptoms until complications (e.g., PID) have occurred. Both symptomatic and asymptomatic cases of PID can result in tubal scarring that can lead to infertility or ectopic pregnancy. Because gonococcal infections among women often are asymptomatic, an important component of gonorrhea control in the United States continues to be the screening of women at high risk for STDs.

Dual Therapy for Gonococcal and Chlamydial Infections

Patients infected with *N. gonorrhoeae* often are coinfected with *C. trachomatis*; this finding led to the recommendation that patients treated for gonococcal infection also be treated routinely with a regimen effective against uncomplicated genital *C. trachomatis* infection. Routine dual therapy without testing for chlamydia can be cost-effective for populations in which chlamydial infection accompanies 10%–30% of gonococcal infections, because the cost of therapy for chlamydia (e.g., $0.50–$1.50 for doxycycline) is less than the cost of testing. Some specialists believe that the routine use of dual therapy has resulted in substantial decreases in the prevalence of chlamydial infection. Because most gonococci in the United States are susceptible to doxycycline and azithromycin, routine cotreatment may hinder the development of antimicrobial-resistant *N. gonorrhoeae*.

Since the introduction of dual therapy, the prevalence of chlamydial infection has decreased in some populations, and simultaneous testing for chlamydial infection has become quicker, more sensitive, and more widely available. In geographic areas in which the rates of coinfection are low, some clinicians might prefer a highly sensitive test for chlamydia rather than treating presumptively. However, presumptive treatment is indicated for patients who may not return for test results.

Quinolone-resistant *N. gonorrhoeae* (QRNG)

QRNG continues to spread, making the treatment of gonorrhea with quinolones inadvisable in many areas. QRNG is common in parts of Asia and the Pacific. In the United States, QRNG is becoming increasingly common in areas on the West Coast. Of 5,461 isolates collected by CDC's Gonococcal Isolate Surveillance Project (GISP) during 2000, 19 (0.4%) had minimum inhibitory concentrations (MICs) ≥1.0 µg/mL to ciprofloxacin. GISP indicated that the resistant isolates made up 0.2% of the samples collected from the 25 cities within the continental United States and Alaska; however, such isolates comprised 14.3% of the Honolulu GISP sample. Because of these and other data, quinolones are no longer recommended for the treatment of gonorrhea in the State of Hawaii and should not be used to treat infections that may have been acquired in Asia or the Pacific (including Hawaii). Recent data from several GISP sites in California demonstrate an increased prevalence of QRNG; therefore, the use of fluoroquinolones in California is probably inadvisable. Clinicians should obtain a recent travel history, including histories from sex partners, in those persons with gonorrhea to ensure appropriate antibiotic therapy.

Resistance of *N. gonorrhoeae* to fluoroquinolones and other antimicrobials is expected to continue to spread; therefore, surveillance for antimicrobial resistance is crucial for guiding therapy recommendations. The GISP, which samples approximately 3% of all U.S. men who have gonococcal infections, is a mainstay of surveillance. However, surveillance by clinicians is also important. Clinicians who diagnose *N. gonorrhoeae* infection in a person who was treated with a recommended regimen and who likely has not been re-exposed should perform culture and susceptibility testing of relevant clinical specimens and report the case to the local health department.

Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum

Recommended Regimens

Cefixime 400 mg orally in a single dose,
OR
Ceftriaxone 125 mg IM in a single dose,
OR
Ciprofloxacin 500 mg orally in a single dose,[§§]
OR
Ofloxacin 400 mg orally in a single dose,[§§]
OR
Levofloxacin 250 mg orally in a single dose,[§§]
PLUS,
IF CHLAMYDIAL INFECTION IS NOT RULED OUT
Azithromycin 1 g orally in a single dose
OR
Doxycycline 100 mg orally twice a day for 7 days.

Cefixime has an antimicrobial spectrum similar to that of ceftriaxone, but the 400-mg oral dose does not provide as high nor as sustained a bactericidal level as that provided by the 125-mg dose of ceftriaxone. In published clinical trials, the 400-mg dose cured 97.4% of uncomplicated urogenital and anorectal gonococcal infections (*50*). The advantage of cefixime is that it can be administered orally.

Ceftriaxone in a single injection of 125 mg provides sustained, high bactericidal levels in the blood. Extensive clinical experience indicates that ceftriaxone is safe and effective for the treatment of uncomplicated gonorrhea at all anatomic sites, curing 99.1% of uncomplicated urogenital and anorectal infections in published clinical trials (*50*).

Ciprofloxacin is effective against most strains of *N. gonorrhoeae* in the United States (excluding Hawaii). At a dose of 500 mg, ciprofloxacin provides sustained bactericidal levels in the blood; in published clinical trials, it has cured 99.8% of uncomplicated urogenital and anorectal infections. Ciprofloxacin is safe, inexpensive, and can be administered orally.

Ofloxacin also is effective against most strains of *N. gonorrhoeae* in the United States (excluding Hawaii), and it has favorable pharmacokinetics. The 400-mg oral dose has been effective for treatment of uncomplicated urogenital and anorectal infections, curing 98.6% of infections in published clinical trials. Levofloxacin, the active *l*-isomer of ofloxacin, can be used in place of ofloxacin as a single dose of 250 mg.

[§§] Quinolones should not be used for infections acquired in Asia or the Pacific, including Hawaii. In addition, use of quinolones is probably inadvisable for treating infections acquired in California and in other areas with increased prevalence of quinolone resistance.

Alternative Regimens

Spectinomycin 2 g in a single, IM dose. Spectinomycin is expensive and must be injected; however, it has been effective in published clinical trials, curing 98.2% of uncomplicated urogenital and anorectal gonococcal infections. Spectinomycin is useful for treatment of patients who cannot tolerate cephalosporins and quinolones.

Single-dose cephalosporin regimens (other than ceftriaxone 125 mg IM and cefixime 400 mg orally) that are safe and highly effective against uncomplicated urogenital and anorectal gonococcal infections include ceftizoxime (500 mg, administered IM), cefoxitin (2 g, administered IM with probenecid 1 g orally), and cefotaxime (500 mg, administered IM). None of the injectable cephalosporins offer any advantage over ceftriaxone.

Single-dose quinolone regimens include gatifloxacin 400 mg orally, norfloxacin 800 mg orally, and lomefloxacin 400 mg orally. These regimens appear to be safe and effective for the treatment of uncomplicated gonorrhea, but data regarding their use are limited. None of the regimens appear to offer any advantage over ciprofloxacin at a dose of 500 mg, ofloxacin at 400 mg, or levofloxacin at 250 mg.

Many other antimicrobials are active against *N. gonorrhoeae,* but none have substantial advantages over the recommended regimens. Azithromycin 2 g orally is effective against uncomplicated gonococcal infection, but it is expensive and causes gastrointestinal distress, so it is not recommended for treatment of gonorrhea. At an oral dose of 1 g, azithromycin is insufficiently effective and is not recommended.

Uncomplicated Gonococcal Infections of the Pharynx

Gonococcal infections of the pharynx are more difficult to eradicate than infections at urogenital and anorectal sites. Few antimicrobial regimens can reliably cure >90% of infections.

Although chlamydial coinfection of the pharynx is unusual, coinfection at genital sites sometimes occurs. Therefore, treatment for both gonorrhea and chlamydia is recommended.

Recommended Regimens

Ceftriaxone 125 mg IM in a single dose
OR
Ciprofloxacin 500 mg orally in a single dose[§§]
PLUS,
IF CHLAMYDIAL INFECTION IS NOT RULED OUT

Azithromycin 1 g orally in a single dose
OR
Doxycycline 100 mg orally twice daily for 7 days.

Follow-Up

Patients who have uncomplicated gonorrhea and who are treated with any of the recommended regimens need not return for a test to confirm that they are cured. Patients who have symptoms that persist after treatment should be evaluated by culture for *N. gonorrhoeae*, and any gonococci isolated should be tested for antimicrobial susceptibility. Infections identified after treatment with one of the recommended regimens usually result from reinfection rather than treatment failure, indicating a need for improved patient education and referral of sex partners. Persistent urethritis, cervicitis, or proctitis also may be caused by *C. trachomatis* and other organisms.

Management of Sex Partners

Patients should be instructed to refer their sex partners for evaluation and treatment. All sex partners of patients who have *N. gonorrhoeae* infection should be evaluated and treated for *N. gonorrhoeae* and *C. trachomatis* infections if their last sexual contact with the patient was within 60 days before onset of symptoms or diagnosis of infection in the patient. If a patient's last sexual intercourse was >60 days before onset of symptoms or diagnosis, the patient's most recent sex partner should be treated. Patients should be instructed to avoid sexual intercourse until therapy is completed and until they and their sex partners no longer have symptoms.

Special Considerations

Allergy, Intolerance, and Adverse Reactions

Persons who cannot tolerate cephalosporins or quinolones should be treated with spectinomycin. Because spectinomycin is unreliable (i.e., only 52% effective) against pharyngeal infections, patients who have suspected or known pharyngeal infection should have a pharyngeal culture evaluated 3–5 days after treatment to verify eradication of infection.

Pregnancy

Pregnant women should not be treated with quinolones or tetracyclines. Those infected with *N. gonorrhoeae* should be treated with a recommended or alternate cephalosporin. Women who cannot tolerate a cephalosporin should be administered a single, 2-g dose of spectinomycin IM. Either erythromycin or amoxicillin is recommended for treatment of presumptive or diagnosed *C. trachomatis* infection during pregnancy (see Chlamydial Infection).

Administration of Quinolones to Adolescents

Fluoroquinolones have not been recommended for persons aged <18 years because studies have indicated that they can damage articular cartilage in some young animals. However, no joint damage attributable to quinolone therapy has been observed in children treated with prolonged ciprofloxacin regimens. Thus, children who weigh >45 kg can be treated with any regimen recommended for adults (See Gonococcal Infections).

HIV Infection

Patients who have gonococcal infection and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Gonococcal Conjunctivitis

In the only published study of the treatment of gonococcal conjunctivitis among U.S. adults, all 12 study participants responded to a single 1-g IM injection of ceftriaxone (*51*). The following recommendations reflect the opinions of consultants knowledgeable in the field of STDs.

Recommended Regimen

Ceftriaxone 1 g IM in a single dose.

NOTE: Consider lavage of the infected eye with saline solution once.

Management of Sex Partners

Patients should be instructed to refer their sex partners for evaluation and treatment (see Gonococcal Infection, Management of Sex Partners).

Disseminated Gonococcal Infection (DGI)

DGI results from gonococcal bacteremia. DGI often results in petechial or pustular acral skin lesions, asymmetrical arthralgia, tenosynovitis, or septic arthritis. The infection is complicated occasionally by perihepatitis and rarely by endocarditis or meningitis. Some strains of *N. gonorrhoeae* that cause DGI may cause minimal genital inflammation.

No recent studies of the treatment of DGI among U.S. adults have been published. The following recommendations reflect the opinions of consultants knowledgeable in the STD field. No treatment failures have been reported using the following recommended regimen.

Treatment

Hospitalization is recommended for initial therapy, especially for patients who may not comply with treatment, for those in whom diagnosis is uncertain, and for those who have purulent synovial effusions or other complications. Patients

should be examined for clinical evidence of endocarditis and meningitis. Patients treated for DGI should be treated presumptively for concurrent *C. trachomatis* infection, unless appropriate testing excludes this infection.

Recommended Regimen

Ceftriaxone 1 g IM or IV every 24 hours.

Alternative Regimens

Cefotaxime 1 g IV every 8 hours,
OR
Ceftizoxime 1 g IV every 8 hours,
OR
Ciprofloxacin 400 mg IV every 12 hours,[§§]
OR
Ofloxacin 400 mg IV every 12 hours,[§§]
OR
Levofloxacin 250 mg IV daily,[§§]
OR
Spectinomycin 2 g IM every 12 hours.

All of the preceding regimens should be continued for 24–48 hours after improvement begins, at which time therapy may be switched to one of the following regimens to complete at least 1 week of antimicrobial therapy.

Cefixime 400 mg orally twice daily,
OR
Ciprofloxacin 500 mg orally twice daily,[§§]
OR
Ofloxacin 400 mg orally twice daily,[§§]
OR
Levofloxacin 500 mg orally once daily.[§§]

Management of Sex Partners

Gonococcal infection often is asymptomatic in sex partners of patients who have DGI. As with uncomplicated gonococcal infections, patients should be instructed to refer their sex partners for evaluation and treatment (see Gonococcal Infection, Management of Sex Partners).

Gonococcal Meningitis and Endocarditis

Recommended Regimen

Ceftriaxone 1–2 g IV every 12 hours.

Therapy for meningitis should be continued for 10–14 days; therapy for endocarditis should be continued for at least 4 weeks. Treatment of complicated DGI should be undertaken in consultation with a specialist.

Management of Sex Partners

Patients should be instructed to refer their sex partners for evaluation and treatment (see Gonococcal Infection, Management of Sex Partners).

Gonococcal Infections Among Infants

Gonococcal infection among infants usually results from exposure to infected cervical exudate at birth. It is usually an acute illness that becomes manifest 2–5 days after birth. The prevalence of infection among infants depends on the prevalence of infection among pregnant women, on whether pregnant women are screened for gonorrhea, and on whether newborns receive ophthalmia prophylaxis.

The most severe manifestations of *N. gonorrhoeae* infection in newborns are ophthalmia neonatorum and sepsis, including arthritis and meningitis. Less severe manifestations include rhinitis, vaginitis, urethritis, and inflammation at sites of fetal monitoring.

Ophthalmia Neonatorum Caused by *N. gonorrhoeae*

In the United States, although *N. gonorrhoeae* causes ophthalmia neonatorum less often than *C. trachomatis* and nonsexually transmitted agents, identifying and treating this infection is especially important because ophthalmia neonatorum can result in perforation of the globe of the eye and blindness.

Diagnostic Considerations

Infants at increased risk for gonococcal ophthalmia are those who do not receive ophthalmia prophylaxis and those whose mothers have had no prenatal care or whose mothers have a history of STDs or substance abuse. Gonococcal ophthalmia is strongly suspected when intracellular Gram-negative diplococci are identified in conjunctival exudate, justifying presumptive treatment for gonorrhea after appropriate cultures for *N. gonorrhoeae* are obtained. Appropriate chlamydial testing should be done simultaneously. Presumptive treatment for *N. gonorrhoeae* may be indicated for newborns who are at increased risk for gonococcal ophthalmia and who have conjunctivitis but do not have gonococci in a Gram-stained smear of conjunctival exudate.

In all cases of neonatal conjunctivitis, conjunctival exudate should be cultured for *N. gonorrhoeae* and tested for antibiotic susceptibility before a definitive diagnosis is made. A definitive diagnosis is important because of the public health and social consequences of a diagnosis of gonorrhea. Nongonococcal causes of neonatal ophthalmia include *Moraxella catarrhalis* and other *Neisseria* species that are

indistinguishable from *N. gonorrhoeae* on Gram-stained smear but can be differentiated in the microbiology laboratory.

Recommended Regimen

Ceftriaxone 25–50 mg/kg IV or IM in a single dose, not to exceed 125 mg.

NOTE: Topical antibiotic therapy alone is inadequate and is unnecessary if systemic treatment is administered.

Other Management Considerations

Simultaneous infection with *C. trachomatis* should be considered when a patient does not improve after treatment. Both mother and infant should be tested for chlamydial infection at the same time that gonorrhea testing is conducted (see Ophthalmia Neonatorum Caused by *C. trachomatis*). Ceftriaxone should be administered cautiously to hyperbilirubinemic infants, especially those born prematurely.

Follow-Up

Infants who have gonococcal ophthalmia should be hospitalized and evaluated for signs of disseminated infection (e.g., sepsis, arthritis, and meningitis). One dose of ceftriaxone is adequate therapy for gonococcal conjunctivitis.

Management of Mothers and Their Sex Partners

The mothers of infants who have gonococcal infection and the mothers' sex partners should be evaluated and treated according to the recommendations for treating gonococcal infections in adults (see Gonococcal Infection in Adolescents and Adults).

Disseminated Gonococcal Infection and Gonococcal Scalp Abscesses in Newborns

Sepsis, arthritis, and meningitis (or any combination of these conditions) are rare complications of neonatal gonococcal infection. Localized gonococcal infection of the scalp can result from fetal monitoring through scalp electrodes. Detection of gonococcal infection in neonates who have sepsis, arthritis, meningitis, or scalp abscesses requires cultures of blood, CSF, and joint aspirate on chocolate agar. Specimens obtained from the conjunctiva, vagina, oropharynx, and rectum that are cultured on gonococcal selective medium are useful for identifying the primary site(s) of infection, especially if inflammation is present. Positive Gram-stained smears of exudate, CSF, or joint aspirate provide a presumptive basis for initiating treatment for *N. gonorrhoeae*. Diagnoses based on Gram-stained smears or presumptive identification of cultures should be confirmed with definitive tests on culture isolates.

Recommended Regimen

Ceftriaxone 25–50 mg/kg/day IV or IM in a single daily dose for 7 days, with a duration of 10–14 days, if meningitis is documented

OR

Cefotaxime 25 mg/kg IV or IM every 12 hours for 7 days, with a duration of 10–14 days, if meningitis is documented.

Prophylactic Treatment for Infants Whose Mothers Have Gonococcal Infection

Infants born to mothers who have untreated gonorrhea are at high risk for infection.

Recommended Regimen in the Absence of Signs of Gonococcal Infection

Ceftriaxone 25–50 mg/kg IV or IM, not to exceed 125 mg, in a single dose.

Other Management Considerations

Both mother and infant should be tested for chlamydial infection.

Follow-Up

Follow-up examination is not required.

Management of Mothers and Their Sex Partners

The mothers of infants who have gonococcal infection and the mothers' sex partners should be evaluated and treated according to the recommendations for treatment of gonococcal infections in adults (see Gonococcal Infection).

Gonococcal Infections Among Children

Sexual abuse is the most frequent cause of gonococcal infection in pre-adolescent children (see Sexual Assault or Abuse of Children). Vaginitis is the most common manifestation of gonococcal infection in preadolescent girls. PID following vaginal infection is probably less common in children than among adults. Among sexually abused children, anorectal and pharyngeal infections with *N. gonorrhoeae* are common and frequently asymptomatic.

Diagnostic Considerations

Because of the legal implications of a diagnosis of *N. gonorrhoeae* infection in a child, only standard culture procedures for the isolation of *N. gonorrhoeae* should be used for children. Nonculture gonococcal tests for gonococci (e.g., Gram-stained smear, DNA probes, EIA, and NAAT tests)

should not be used alone; none of these tests have been approved by FDA for use with specimens obtained from the oropharynx, rectum, or genital tract of children. Specimens from the vagina, urethra, pharynx, or rectum should be streaked onto selective media for isolation of *N. gonorrhoeae*, and all presumptive isolates of *N. gonorrhoeae* should be identified definitively by at least two tests that involve different principles (e.g., biochemical, enzyme substrate, or serologic). Isolates should be preserved to enable additional or repeated testing.

Recommended Regimens for Children Who Weigh ≥45 kg

Treat with one of the regimens recommended for adults (see Gonococcal Infections).

NOTE: Fluoroquinolones have not been recommended for persons aged <18 years because they have damaged articular cartilage in young animals. However, no such joint damage clearly attributable to quinolone therapy has been observed in children, even in those receiving multiple-dose regimens.

Recommended Regimens for Children Who Weigh <45 kg and Who Have Uncomplicated Gonococcal Vulvovaginitis, Cervicitis, Urethritis, Pharyngitis, or Proctitis

Ceftriaxone 125 mg IM in a single dose.

Alternative Regimen

Spectinomycin 40 mg/kg (maximum dose: 2 g) IM in a single dose may be used, but this therapy is unreliable for treatment of pharyngeal infections. Some specialists use cefixime to treat gonococcal infections in children because it can be administered orally; however, no reports have been published concerning the safety or effectiveness of cefixime used for this purpose.

Recommended Regimen for Children Who Weigh <45 kg and Who Have Bacteremia or Arthritis

Ceftriaxone 50 mg/kg (maximum dose: 1 g) IM or IV in a single dose daily for 7 days.

Recommended Regimen for Children Who Weigh ≥45 kg and Who Have Bacteremia or Arthritis

Ceftriaxone 50 mg/kg IM or IV in a single dose daily for 7 days.

Follow-Up

Follow-up cultures are unnecessary if ceftriaxone is used. If spectinomycin is used to treat pharyngitis, a follow-up culture is necessary to ensure that treatment was effective.

Other Management Considerations

Only parenteral cephalosporins are recommended for use in children. Ceftriaxone is approved for all gonococcal infections in children; cefotaxime is approved for gonococcal ophthalmia only. Oral cephalosporins used for treatment of gonococcal infections in children have not been adequately evaluated.

All children who have gonococcal infections should be evaluated for coinfection with syphilis and *C. trachomatis*. (For a discussion of concerns regarding sexual assault, refer to Sexual Assault or Abuse of Children.)

Ophthalmia Neonatorum Prophylaxis

To prevent gonococcal ophthalmia neonatorum, a prophylactic agent should be instilled into the eyes of all newborn infants; this procedure is required by law in most states. All of the recommended prophylactic regimens in this section prevent gonococcal ophthalmia. However, the efficacy of these preparations in preventing chlamydial ophthalmia is less clear, and they do not eliminate nasopharyngeal colonization by *C. trachomatis*. The diagnosis and treatment of gonococcal and chlamydial infections in pregnant women is the best method for preventing neonatal gonococcal and chlamydial disease. Not all women, however, receive prenatal care. Ocular prophylaxis is warranted because it can prevent sight-threatening gonococcal ophthalmia and because it is safe, easy to administer, and inexpensive.

Prophylaxis

Recommended Regimens

Silver nitrate (1%) aqueous solution in a single application,[¶¶]

OR

Erythromycin (0.5%) ophthalmic ointment in a single application,

OR

Tetracycline ophthalmic ointment (1%) in a single application.

One of these recommended preparations should be instilled into both eyes of every neonate as soon as possible after delivery. If prophylaxis is delayed (i.e., not administered in the delivery room), a monitoring system should be established to

[¶¶] The availability of silver nitrate in the United States may be limited.

ensure that all infants receive prophylaxis. All infants should be administered ocular prophylaxis, regardless of whether they are delivered vaginally or by cesarean section. Single-use tubes or ampules are preferable to multiple-use tubes. Bacitracin is not effective. Use of povidone iodine has not been studied adequately.

Diseases Characterized by Vaginal Discharge

Management of Patients Who Have Vaginal Infections

Vaginal infection is usually characterized by a vaginal discharge or vulvar itching and irritation; a vaginal odor may be present. The three diseases most frequently associated with vaginal discharge are trichomoniasis (caused by *T. vaginalis*), bacterial vaginosis (caused by a replacement of the normal vaginal flora by an overgrowth of anaerobic microorganisms, mycoplasmas, and *Gardnerella vaginalis*), and candidiasis (usually caused by *Candida albicans*). MPC caused by *C. trachomatis* or *N. gonorrhoeae* can sometimes cause vaginal discharge. Although vulvovaginal candidiasis and bacterial vaginosis are not usually transmitted sexually, they are included in this section because these infections are often diagnosed in women being evaluated for STDs.

The cause of vaginal infection can be diagnosed by pH and microscopic examination of the discharge. The pH of the vaginal secretions can be determined by narrow-range pH paper for the elevated pH (>4.5) typical of BV or trichomoniasis. Discharge can be examined by diluting one sample in one to two drops of 0.9% normal saline solution on one slide and a second sample in 10% potassium hydroxide (KOH) solution. An amine odor detected before or immediately after applying KOH suggests BV. A cover slip is placed on the slides, and they are examined under a microscope at low- and high-dry power. The motile *T. vaginalis* or the clue cells of BV usually are identified easily in the saline specimen. The yeast or pseudohyphae of *Candida* species are more easily identified in the KOH specimen. However, their absence does not preclude candidal or trichomonal infection, because several studies have demonstrated the presence of these pathogens by using polymerase chain reaction (PCR) after a negative microscopic exam. The presence of objective signs of external vulvar inflammation in the absence of vaginal pathogens, along with a minimal amount of discharge, suggests the possibility of mechanical, chemical, allergic, or other noninfectious irritation of the vulva. Culture for *T. vaginalis* is more sensitive than microscopic examination. Laboratory testing fails to identify the cause of vaginitis among a minority of women.

Bacterial Vaginosis

BV is a clinical syndrome resulting from replacement of the normal H_2O_2-producing *Lactobacillus* sp. in the vagina with high concentrations of anaerobic bacteria (e.g., *Prevotella* sp. and *Mobiluncus* sp.), *G. vaginalis*, and *Mycoplasma hominis*. BV is the most prevalent cause of vaginal discharge or malodor; however, up to 50% of women with BV may not report symptoms of BV. The cause of the microbial alteration is not fully understood. BV is associated with having multiple sex partners, douching, and lack of vaginal lactobacilli; it is unclear whether BV results from acquisition of a sexually transmitted pathogen. Women who have never been sexually active are rarely affected. Treatment of the male sex partner has not been beneficial in preventing the recurrence of BV.

Diagnostic Considerations

BV can be diagnosed by the use of clinical or Gram-stain criteria. Clinical criteria require three of the following symptoms or signs:

- a homogeneous, white, noninflammatory discharge that smoothly coats the vaginal walls;
- the presence of clue cells on microscopic examination;
- a pH of vaginal fluid >4.5; and
- a fishy odor of vaginal discharge before or after addition of 10% KOH (i.e., the whiff test).

When a Gram stain is used, determining the relative concentration of the bacterial morphotypes characteristic of the altered flora of BV is an acceptable laboratory method for diagnosing BV. Culture of *G. vaginalis* is not recommended as a diagnostic tool because it is not specific. However, a DNA probe based test for high concentrations of *G. vaginalis* (Affirm™ VP III, manufactured by Becton Dickinson, Sparks, Maryland) may have clinical utility. Cervical Pap tests have limited clinical utility for the diagnosis of BV because of low sensitivity. Other commercially available tests that may be useful for the diagnosis of BV include a card test for the detection of elevated pH and trimethylamine (FemExam® test card, manufactured by Cooper Surgical, Shelton, Connecticut) and prolineaminopeptidase (Pip Activity TestCard™, manufactured by Litmus Concepts, Inc., Santa Clara, California).

Treatment

The established benefits of therapy for BV in non-pregnant women are to a) relieve vaginal symptoms and signs of infection and b) reduce the risk for infectious complications after abortion or hysterectomy. Other potential benefits include the reduction of other infectious complications (e.g., HIV and other STDs). All women who have symptomatic disease require treatment.

BV during pregnancy is associated with adverse pregnancy outcomes, including premature rupture of the membranes, preterm labor, preterm birth, and postpartum endometritis. The established benefit of therapy for BV in pregnant women is to relieve vaginal symptoms and signs of infection. Additional potential benefits of therapy include a) reducing the risk for infectious complications associated with BV during pregnancy and b) reducing the risk for other infections (e.g., other STDs or HIV). The results of several investigations indicate that treatment of pregnant women who have BV and who are at high risk for preterm delivery (i.e., those who previously delivered a premature infant) may reduce the risk for prematurity (*52–54*). Therefore, high-risk pregnant women who have asymptomatic BV may be evaluated for treatment.

The bacterial flora that characterizes BV have been recovered from the endometria and salpinges of women who have PID. BV has been associated with endometritis, PID, and vaginal cuff cellulitis after invasive procedures, including endometrial biopsy, hysterectomy, hysterosalpingography, placement of an IUD, cesarean section, and uterine curettage. The results of two randomized controlled trials indicated that treatment of BV with metronidazole substantially reduced postabortion PID (*55,56*). Three trials that evaluated the use of anaerobic antimicrobial coverage (metronidazole) for routine operative prophylaxis before abortion and seven trials that evaluated this additional coverage for women undergoing hysterectomy found a substantial reduction (range: 10%–75%) in post-operative infectious complications (*57–66*). Because of the increased risk for postoperative infectious complications associated with BV, some specialists recommend that before performing surgical abortion or hysterectomy, providers screen and treat women with BV in addition to providing routine prophylaxis. However, more information is needed before recommending treatment of asymptomatic BV before other invasive procedures.

Recommended Regimens

Metronidazole 500 mg orally twice a day for 7 days,

OR

Metronidazole gel 0.75%, one full applicator (5 g) intravaginally, once a day for 5 days,

OR

Clindamycin cream 2%, one full applicator (5 g) intravaginally at bedtime for 7 days.

NOTE: Patients should be advised to avoid consuming alcohol during treatment with metronidazole and for 24 hours thereafter. Clindamycin cream and ovules are oil-based and might weaken latex condoms and diaphragms. Refer to condom product labeling for additional information.

The recommended metronidazole regimens are equally efficacious. The vaginal clindamycin cream appears less efficacious than the metronidazole regimens. The alternative regimens have lower efficacy for BV.

Alternative Regimens

Metronidazole 2 g orally in a single dose,

OR

Clindamycin 300 mg orally twice a day for 7 days,

OR

Clindamycin ovules 100 g intravaginally once at bedtime for 3 days.

One randomized trial evaluating the clinical equivalency of intravaginal metronidazole gel 0.75% once daily versus twice daily found similar cure rates 1 month after therapy (*67*). One randomized trial that evaluated the equivalency of clindamycin cream and clindamycin ovules found that cure rates did not differ significantly (*68*). Metronidazole 2 g single-dose therapy is an alternative regimen because of its lower efficacy for treatment of BV. Although FDA has approved metronidazole 750-mg extended release tablets once daily for 7 days, no data have been published on the clinical equivalency of this regimen with other regimens.

Studies are currently underway to evaluate the efficacy of vaginal lactobacilli suppositories in addition to oral metronidazole for the treatment of BV. No data support the use of non-vaginal lactobacilli or douching for the treatment of BV.

Follow-Up

Follow-up visits are unnecessary if symptoms resolve. Because recurrence of BV is not unusual, women should be advised to return for additional therapy if symptoms recur. Another recommended treatment regimen may be used to treat recurrent disease. No long-term maintenance regimen with any therapeutic agent is recommended.

Management of Sex Partners

The results of clinical trials indicate that a woman's response to therapy and the likelihood of relapse or recurrence are not affected by treatment of her sex partner(s) (*69–71*). Therefore, routine treatment of sex partners is not recommended.

Special Considerations

Allergy or Intolerance to the Recommended Therapy

Clindamycin cream or oral clindamycin is preferred in case of allergy or intolerance to metronidazole. Metronidazole gel can be considered for patients who do not tolerate systemic metronidazole, but patients allergic to oral metronidazole should not be administered metronidazole vaginally.

Pregnancy

All symptomatic pregnant women should be tested and treated. BV has been associated with adverse pregnancy outcomes (e.g., premature rupture of the membranes, chorioamnionitis, preterm labor, preterm birth, postpartum endometritis, and post-cesarean wound infection). Some specialists prefer using systemic therapy to treat possible subclinical upper genital tract infections among women at low risk for preterm delivery (i.e., those who have no history of delivering an infant before term). Existing data do not support the use of topical agents during pregnancy. Evidence from three trials suggests an increase in adverse events (e.g., prematurity and neonatal infections), particularly in newborns, after use of clindamycin cream (*72–74*). Multiple studies and meta-analyses have not demonstrated a consistent association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns (*75–77*).

Recommended Regimens

Metronidazole 250 mg orally three times a day for 7 days

OR

Clindamycin 300 mg orally twice a day for 7 days.

Because treatment of BV in asymptomatic pregnant women at high risk for preterm delivery (i.e., those who have previously delivered a premature infant) with a recommended regimen has reduced preterm delivery in three of four randomized controlled trials (*52–54,78*), some specialists recommend the screening and treatment of these women. However, the optimal treatment regimens have not been established. The screening (if conducted) and treatment should be performed at the first prenatal visit.

The two trials that examined the use of metronidazole during pregnancy used the 250-mg regimen; the recommended regimen for BV in nonpregnant women is 500 mg twice daily. Some specialists also recommend this higher dose for treatment of pregnant women. In one published study, women with BV were treated at 19 weeks with a regimen of an initial dose of 2 g, followed by a 2-g dose 2 days later; the regimen was repeated 4 weeks later (*78*). This regimen was not effective in reducing preterm birth in any group of women.

Data are conflicting regarding whether treatment of asymptomatic pregnant women who are at low risk for preterm delivery reduces adverse outcomes of pregnancy. Several unpublished trials have evaluated screening and treatment for BV among asymptomatic low-risk pregnant women in the first or early second trimester. One trial, using oral clindamycin, demonstrated a reduction in spontaneous preterm birth; another indicated a reduction in postpartum infectious complications (*79*).

Follow-Up of Pregnant Women

Treatment of BV in asymptomatic pregnant women who are at high risk for preterm delivery might prevent adverse pregnancy outcomes. Therefore, a follow-up evaluation 1 month after completion of treatment should be considered to evaluate whether therapy was effective.

HIV Infection

Patients who have BV and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Trichomoniasis

Trichomoniasis is caused by the protozoan *T. vaginalis*. Most men who are infected with *T. vaginalis* do not have symptoms; others have NGU. Many infected women have symptoms characterized by a diffuse, malodorous, yellow-green discharge with vulvar irritation. However, some women have minimal or no symptoms. Diagnosis of vaginal trichomoniasis is usually performed by microscopy of vaginal secretions, but this method has a sensitivity of only about 60%–70%. Culture is the most sensitive commercially available method of diagnosis. No FDA-approved PCR test for *T. vaginalis* is available in the United States, but such testing may be available from commercial laboratories that have developed their own PCR tests.

Recommended Regimen

Metronidazole 2 g orally in a single dose.

Alternative Regimen

Metronidazole 500 mg twice a day for 7 days.

The nitroimidazoles comprise the only class of drugs useful for the oral or parenteral therapy of trichomoniasis. Of these, only metronidazole is readily available in the United States and approved by the FDA for the treatment of trichomoniasis. In randomized clinical trials, the recommended metronidazole regimens have resulted in cure rates of approximately 90%–95%; ensuring treatment of sex partners might increase this rate. Treatment of patients and sex partners results in relief of symptoms, microbiologic cure, and reduction of transmission. Metronidazole gel has been approved for treatment of BV. However, like other topically applied antimicrobials that are unlikely to achieve therapeutic levels in the urethra or perivaginal glands, it is considerably less efficacious for treatment of trichomoniasis (≤50%) than oral preparations of metronidazole. Therefore, metronidazole gel is not recommended for use. Several other topically applied antimicrobials have occasionally been used for treatment of trichomoniasis, but it

is unlikely that these preparations have greater efficacy than metronidazole gel.

Follow-Up

Follow-up is unnecessary for men and women who become asymptomatic after treatment or who are initially asymptomatic. Certain strains of *T. vaginalis* can have diminished susceptibility to metronidazole; however, infections caused by most of these organisms respond to higher doses of metronidazole. If treatment failure occurs with either regimen, the patient should be re-treated with metronidazole 500 mg twice a day for 7 days. If treatment failure occurs again, the patient should be treated with a single, 2-g dose of metronidazole once a day for 3–5 days.

Patients with laboratory-documented infection who do not respond to the 3–5 day treatment regimen and who have not been reinfected should be managed in consultation with a specialist; evaluation of such cases should ideally include determination of the susceptibility of *T. vaginalis* to metronidazole. Consultation is available from CDC (tel: 770-488-4115; website: http://www.cdc.gov/std/).

Management of Sex Partners

Sex partners of patients with *T. vaginalis* should be treated. Patients should be instructed to avoid sex until they and their sex partners are cured (i.e., when therapy has been completed and patient and partner(s) are asymptomatic [in the absence of a microbiologic test of cure]).

Special Considerations

Allergy, Intolerance, and Adverse Reactions

Patients with an immediate-type allergy to metronidazole can be managed by desensitization (*80*). Topical therapy with drugs other than nitroimidazoles can be attempted, but cure rates are low (≤50%).

Pregnancy

Vaginal trichomoniasis has been associated with adverse pregnancy outcomes, particularly premature rupture of the membranes, preterm delivery, and low birthweight. Data have not indicated that treating asymptomatic trichomoniasis during pregnancy lessens that association (*81*). Women who are symptomatic with trichomoniasis should be treated to ameliorate symptoms.

Women may be treated with 2 g of metronidazole in a single dose. Multiple studies and meta-analyses have not demonstrated a consistent association between metronidazole use during pregnancy and teratogenic or mutagenic effects in infants (*75–77*).

HIV Infection

Patients who have trichomoniasis and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Vulvovaginal Candidiasis

Vulvovaginal candidiasis (VVC) usually is caused by *C. albicans* but occasionally is caused by other *Candida* sp. or yeasts. Typical symptoms of VVC include pruritus and vaginal discharge. Other symptoms include vaginal soreness, vulvar burning, dyspareunia, and external dysuria. None of these symptoms is specific for VVC. An estimated 75% of women will have at least one episode of VVC, and 40%–45% will have two or more episodes. On the basis of clinical presentation, microbiology, host factors, and response to therapy, VVC can be classified as either uncomplicated or complicated (Box 2). Approximately 10%–20% of women will have complicated VVC, suggesting diagnostic and therapeutic considerations.

Box 2. Classification of vulvovaginal candidiasis (VVC)

Uncomplicated VVC

- Sporadic or infrequent vulvovaginal candidiasis
  OR
- Mild-to-moderate vulvovaginal candidiasis
  OR
- Likely to be *C. albicans*
  OR
- Non-immunocompromised women

Complicated VVC

- Recurrent vulvovaginal candidiasis
  OR
- Severe vulvovaginal candidiasis
  OR
- Non-albicans candidiasis
  OR
- Women with uncontrolled diabetes, debilitation, or immunosuppression or those who are pregnant

Uncomplicated VVC

Diagnostic Considerations in Uncomplicated VVC

A diagnosis of *Candida* vaginitis is suggested clinically by pruritus and erythema in the vulvovaginal area; a white discharge may be present. The diagnosis can be made in a woman who has signs and symptoms of vaginitis when either a) a wet preparation (saline, 10% KOH) or Gram stain of vaginal discharge demonstrates yeasts or pseudohyphae or b) a culture or other test yields a positive result for a yeast species. *Candida* vaginitis is associated with a normal vaginal pH (≤4.5). Use of 10% KOH in wet preparations improves the visualization of yeast and mycelia by disrupting cellular material that might obscure the yeast or pseudohyphae. Identifying *Candida* by culture in the absence of symptoms is not an indication for treatment, because approximately 10%–20% of women harbor *Candida* sp. and other yeasts in the vagina. VVC can occur concomitantly with STDs, and treatment of all pathogens present is warranted. Most healthy women with uncomplicated VVC have no precipitating factors. However, in a minority of women who have asymptomatic *Candida* colonization, antibiotic use precipitates VVC.

Treatment

Short-course topical formulations (i.e., single dose and regimens of 1–3 days) effectively treat uncomplicated VVC. The topically applied azole drugs are more effective than nystatin. Treatment with azoles results in relief of symptoms and negative cultures in 80%–90% of patients who complete therapy.

Recommended Regimens

Intravaginal Agents:

Butoconazole 2% cream 5 g intravaginally for 3 days,***

OR

Butoconazole 2% cream 5 g (Butaconazole1-sustained release), single intravaginal application,

OR

Clotrimazole 1% cream 5 g intravaginally for 7–14 days,***

OR

Clotrimazole 100 mg vaginal tablet for 7 days,

OR

Clotrimazole 100 mg vaginal tablet, two tablets for 3 days,

OR

Clotrimazole 500 mg vaginal tablet, one tablet in a single application,

OR

Miconazole 2% cream 5 g intravaginally for 7 days,***

OR

Miconazole 100 mg vaginal suppository, one suppository for 7 days,***

OR

Miconazole 200 mg vaginal suppository, one suppository for 3 days,***

OR

Nystatin 100,000-unit vaginal tablet, one tablet for 14 days,

OR

Tioconazole 6.5% ointment 5 g intravaginally in a single application,***

OR

Terconazole 0.4% cream 5 g intravaginally for 7 days,

OR

Terconazole 0.8% cream 5 g intravaginally for 3 days,

OR

Terconazole 80 mg vaginal suppository, one suppository for 3 days.

Oral Agent:

Fluconazole 150 mg oral tablet, one tablet in single dose.

NOTE: The creams and suppositories in this regimen are oil-based and may weaken latex condoms and diaphragms. Refer to condom product labeling for further information.

Preparations for intravaginal administration of butaconazole, clotrimazole, miconazole, and tioconazole are available over-the-counter (OTC). Self-medication with OTC preparations should be advised only for women who have been diagnosed previously with VVC and who have a recurrence of the same symptoms. Any woman whose symptoms persist after using an OTC preparation or who has a recurrence of symptoms within 2 months should seek medical care. Unnecessary or inappropriate use of OTC preparations is common and can lead to delay of treatment of other etiologies of vulvovaginitis that could result in adverse clinical outcomes.

Follow-Up

Patients should be instructed to return for follow-up visits only if symptoms persist or recur within 2 months of onset of initial symptoms.

Management of Sex Partners

VVC is not usually acquired through sexual intercourse; treatment of sex partners is not recommended but may be considered in women who have recurrent infection. A minority of male sex partners may have balanitis, which is characterized by erythematous areas on the glans of the penis in

*** Over-the-counter (OTC) preparations.

conjunction with pruritus or irritation. These men benefit from treatment with topical antifungal agents to relieve symptoms.

Special Considerations

Allergy to or Intolerance of the Recommended Therapy. Topical agents usually cause no systemic side effects, although local burning or irritation may occur. Oral agents occasionally cause nausea, abdominal pain, and headache. Therapy with the oral azoles has been associated rarely with abnormal elevations of liver enzymes. Clinically important interactions might occur when these oral agents are administered with other drugs, including astemizole, calcium channel antagonists, cisapride, coumadin, cyclosporin A, oral hypoglycemic agents, phenytoin, protease inhibitors, tacrolimus, terfenadine, theophylline, trimetrexate, and rifampin.

Complicated VVC

Recurrent Vulvovaginal Candidiasis

Recurrent VVC (RVVC), usually defined as four or more episodes of symptomatic VVC each year, affects a small percentage of women (<5%). The pathogenesis of RVVC is poorly understood, and most women who have RVVC have no apparent predisposing or underlying conditions. Vaginal cultures should be obtained from patients with RVVC to confirm the clinical diagnosis and to identify unusual species, including non-albicans species, particularly *Candida glabrata* (*C. glabrata* does not form pseudohyphae or hyphae and is not easily recognized on microscopy). *C. glabrata* and other non-albicans *Candidia* species are found in 10%–20% of patients with RVVC. Conventional antimycotic therapies are not as effective against these species as against *C. albicans*.

Treatment

Each individual episode of RVVC caused by *C. albicans* responds well to short duration oral or topical azole therapy. However, to maintain clinical and mycologic control, specialists recommend a longer duration of initial therapy (e.g., 7–14 days of topical therapy or a 150-mg, oral dose of fluconazole repeated 3 days later) to achieve mycologic remission before initiating a maintenance antifungal regimen.

Maintenance Regimens

Maintenance antifungals are selected on the basis of pharmacologic characteristics of individual agents and route of administration. Recommended regimens include clotrimazole (500-mg dose vaginal suppositories once weekly), ketoconazole (100-mg dose once daily), fluconazole (100–150-mg dose once weekly), and itraconazole (400-mg dose once monthly or 100-mg dose once daily). Although all maintenance regimens should be continued for 6 months, an estimated one in 10,000–15,000 persons exposed to ketoconazole may develop hepatotoxicity. Patients receiving long-term ketoconazole should be monitored for toxicity.

Suppressive maintenance antifungal therapies are effective in reducing RVVC. However, 30%–40% of women will have recurrent disease once maintenance therapy is discontinued. Routine treatment of sex partners is controversial. Although *C. albicans* azole resistance is rare in vaginal isolates, surveillance of recurrent isolates for development of resistance is prudent.

Severe VVC

Severe vulvovaginitis (i.e., extensive vulvar erythema, edema, excoriation, and fissure formation) has lower clinical response rates in patients treated with short courses of topical or oral therapy. Either 7–14 days of topical azole or 150 mg of fluconazole in two sequential doses (second dose 72 hours after initial dose) is recommended.

Non-albicans VVC

The optimal treatment of non-*albicans* VVC remains unknown. Longer duration of therapy (7–14 days) with a non-fluconazole azole drug is recommended as first-line therapy. If recurrence occurs, 600 mg of boric acid in a gelatin capsule is recommended, administered vaginally once daily for 2 weeks. This regimen has clinical and mycologic eradication rates of approximately 70%. Additional options include topical 4% flucytosine; however, referral to a specialist is advised. Safety data regarding the long-term use of these regimens are lacking. If non-*albicans* VVC continues to recur, a maintenance regimen of 100,000 units of nystatin delivered daily via vaginal suppositories has been successful.

Compromised Host

Women with underlying debilitating medical conditions (e.g., those with uncontrolled diabetes or those receiving corticosteroid treatment) do not respond as well to short-term therapies. Efforts to correct modifiable conditions should be made, and more prolonged (i.e., 7–14 days) conventional antimycotic treatment is necessary.

Pregnancy

VVC often occurs during pregnancy. Only topical azole therapies, applied for 7 days, are recommended for use among pregnant women.

HIV Infection

The attack rate of VVC in HIV-infected women is unknown. Vaginal *Candida* colonization rates in HIV-infected women are higher than among seronegative women with similar demographic characteristics and high-risk behaviors, and the colonization rates correlate with increasing severity of

immunosuppression. Symptomatic VVC is more frequent in seropositive women and similarly correlates with severity of immunodeficiency. In addition, among HIV-infected women, systemic azole exposure is associated with the isolation of non-*albicans Candida* species from the vagina.

Based on available data, therapy for VVC in HIV-infected women should not differ from that for seronegative women. Although long-term prophylactic therapy with fluconazole at a dose of 200 mg weekly has been effective in reducing *C. albicans* colonization and symptomatic VVC, it is not recommended for routine primary prophylaxis in HIV-infected women in the absence of recurrent VVC. Given the frequency with which RVVC occurs in the immmunocompetent healthy population, RVVC should not be considered a sentinel sign to justify HIV testing.

Pelvic Inflammatory Disease

PID comprises a spectrum of inflammatory disorders of the upper female genital tract, including any combination of endometritis, salpingitis, tubo-ovarian abscess, and pelvic peritonitis. Sexually transmitted organisms, especially *N. gonorrhoeae* and *C. trachomatis*, are implicated in many cases; however, microorganisms that comprise the vaginal flora (e.g., anaerobes, *G. vaginalis, Haemophilus influenzae,* enteric Gram-negative rods, and *Streptococcus agalactiae*) also have been associated with PID. In addition, cytomegalovirus (CMV), *M. hominis,* and *U. urealyticum* may be the etiologic agents in some cases of PID.

Diagnostic Considerations

Acute PID is difficult to diagnose because of the wide variation in the symptoms and signs. Many women with PID have subtle or mild symptoms. Delay in diagnosis and effective treatment probably contributes to inflammatory sequelae in the upper reproductive tract. Laparoscopy can be used to obtain a more accurate diagnosis of salpingitis and a more complete bacteriologic diagnosis. However, this diagnostic tool often is not readily available, and its use is not easy to justify when symptoms are mild or vague. Moreover, laparoscopy will not detect endometritis and may not detect subtle inflammation of the fallopian tubes. Consequently, a diagnosis of PID usually is based on clinical findings.

The clinical diagnosis of acute PID is imprecise. Data indicate that a clinical diagnosis of symptomatic PID has a PPV for salpingitis of 65%–90% compared with laparoscopy. The PPV of a clinical diagnosis of acute PID differs depending on epidemiologic characteristics and the clinical setting, with higher PPV among sexually active young women (particularly adolescents) and among patients attending STD clinics or from settings in which rates of gonorrhea or chlamydia are high. In all settings, however, no single historical, physical, or laboratory finding is both sensitive and specific for the diagnosis of acute PID (i.e., can be used both to detect all cases of PID and to exclude all women without PID). Combinations of diagnostic findings that improve either sensitivity (i.e., detect more women who have PID) or specificity (i.e., exclude more women who do not have PID) do so only at the expense of the other. For example, requiring two or more findings excludes more women who do not have PID but also reduces the number of women with PID who are identified.

Many episodes of PID go unrecognized. Although some cases are asymptomatic, others are undiagnosed because the patient or the health-care provider fails to recognize the implications of mild or nonspecific symptoms or signs (e.g., abnormal bleeding, dyspareunia, and vaginal discharge). Because of the difficulty of diagnosis and the potential for damage to the reproductive health of women even by apparently mild or atypical PID, health-care providers should maintain a low threshold for the diagnosis of PID.

The optimal treatment regimen and long-term outcome of early treatment of women with asymptomatic or atypical PID are unknown. The following recommendations for diagnosing PID are intended to help health-care providers recognize when PID should be suspected and when they need to obtain additional information to increase diagnostic certainty. Diagnosis and management of other common causes of lower abdominal pain (e.g., ectopic pregnancy, acute appendicitis, and functional pain) are unlikely to be impaired by initiating empiric antimicrobial therapy for PID.

Empiric treatment of PID should be initiated in sexually active young women and other women at risk for STDs if the following minimum criteria are present and no other cause(s) for the illness can be identified:

- uterine/adnexal tenderness or
- cervical motion tenderness.

Requiring all minimum criteria may result in low sensitivity in patients at high risk for infection. In patients with both pelvic tenderness and signs of lower genital tract inflammation, the diagnosis of PID should be considered. Treatment may be indicated based on a patient's risk profile.

More elaborate diagnostic evaluation often is needed, because incorrect diagnosis and management might cause unnecessary morbidity. These additional criteria may be used to enhance the specificity of the minimum criteria. Additional criteria that support a diagnosis of PID include the following:

- oral temperature >101 F (>38.3 C);
- abnormal cervical or vaginal mucopurulent discharge;
- presence of white blood cells (WBCs) on saline microscopy of vaginal secretions;
- elevated erythrocyte sedimentation rate;
- elevated C-reactive protein; and
- laboratory documentation of cervical infection with *N. gonorrhoeae* or *C. trachomatis.*

Most women with PID have either mucopurulent cervical discharge or evidence of WBCs on a microscopic evaluation of a saline preparation of vaginal fluid. If the cervical discharge appears normal and no white blood cells are found on the wet prep, the diagnosis of PID is unlikely, and alternative causes of pain should be investigated.

The most specific criteria for diagnosing PID include the following:

- endometrial biopsy with histopathologic evidence of endometritis;
- transvaginal sonography or magnetic resonance imaging techniques showing thickened, fluid-filled tubes with or without free pelvic fluid or tubo-ovarian complex; and
- laparoscopic abnormalities consistent with PID.

A diagnostic evaluation that includes some of these more extensive studies may be warranted in certain cases.

Treatment

PID treatment regimens must provide empiric, broad-spectrum coverage of likely pathogens. Antimicrobial coverage should include *N. gonorrhoeae, C. trachomatis*, anaerobes, Gram-negative facultative bacteria, and streptococci. Several antimicrobial regimens have been effective in achieving clinical and microbiologic cure in randomized clinical trials with short-term follow-up. However, few investigations have assessed and compared these regimens with regard to elimination of infection in the endometrium and fallopian tubes or determined the incidence of long-term complications (e.g., tubal infertility and ectopic pregnancy) of antimicrobial regimens.

All regimens should be effective against *N. gonorrhoeae* and *C. trachomatis,* because negative endocervical screening does not preclude upper reproductive tract infection. The need to eradicate anaerobes from women who have PID has not been determined definitively. Anaerobic bacteria have been isolated from the upper reproductive tract of women who have PID, and data from in vitro studies have revealed that certain anaerobes (e.g., *Bacteroides fragilis*) can cause tubal and epithelial destruction. In addition, BV also is present in many women who have PID. Until treatment regimens that do not adequately cover these microbes have been demonstrated to prevent sequelae as successfully as the regimens that are effective against these microbes, the recommended regimens should provide anaerobic coverage. Treatment should be initiated as soon as the presumptive diagnosis has been made, because prevention of long-term sequelae has been linked directly with immediate administration of appropriate antibiotics. When selecting a treatment regimen, health-care providers should consider availability, cost, patient acceptance, and antimicrobial susceptibility.

In the past, many specialists recommended that all patients who had PID be hospitalized so that bed rest and supervised treatment with parenteral antibiotics could be initiated. However, hospitalization is no longer synonymous with parenteral therapy. No currently available data compare the efficacy of parenteral with oral therapy or inpatient with outpatient treatment settings. The decision of whether hospitalization is necessary should be based on the discretion of the health-care provider.

The following criteria for hospitalization are based on observational data and theoretical concerns:

- surgical emergencies (e.g., appendicitis) cannot be excluded;
- the patient is pregnant;
- the patient does not respond clinically to oral antimicrobial therapy;
- the patient is unable to follow or tolerate an outpatient oral regimen;
- the patient has severe illness, nausea and vomiting, or high fever; and
- the patient has a tubo-ovarian abscess.

No data are available that suggest that adolescent women benefit from hospitalization for treatment of PID. Whether women in their later reproductive years benefit from hospitalization for treatment of PID is also unclear, although women aged ≥35 years who are hospitalized with PID are more likely than are younger women to have a complicated clinical course.

Parenteral Treatment

No efficacy data compare parenteral with oral regimens. Many randomized trials have demonstrated the efficacy of both parenteral and oral regimens (*82*). Although most trials have used parenteral treatment for at least 48 hours after the patient demonstrates substantial clinical improvement, this time designation is arbitrary. Clinical experience should guide decisions regarding transition to oral therapy, which usually can be initiated within 24 hours of clinical improvement. Most clinicians recommend at least 24 hours of direct inpatient observation for patients who have tubo-ovarian abscesses, after which time home antimicrobial therapy is adequate.

Parenteral Regimen A

Cefotetan 2 g IV every 12 hours
OR
Cefoxitin 2 g IV every 6 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours.

NOTE: Because of pain associated with infusion, doxycycline should be administered orally when possible, even when the patient is hospitalized. Both oral and IV administration of doxycycline provide similar bioavailability.

Parenteral therapy may be discontinued 24 hours after a patient improves clinically, and oral therapy with doxycycline (100 mg twice a day) should continue to complete 14 days of therapy. When tubo-ovarian abscess is present, many health-care providers use clindamycin or metronidazole with doxycycline for continued therapy rather than doxycycline alone, because it provides more effective anaerobic coverage.

Clinical data are limited regarding the use of other second- or third-generation cephalosporins (e.g., ceftizoxime, cefotaxime, and ceftriaxone), which also may be effective therapy for PID and may replace cefotetan or cefoxitin. However, these cephalosporins are less active than cefotetan or cefoxitin against anaerobic bacteria.

Parenteral Regimen B

Clindamycin 900 mg IV every 8 hours
PLUS
Gentamicin loading dose IV or IM (2 mg/kg of body weight) followed by a maintenance dose (1.5 mg/kg) every 8 hours. Single daily dosing may be substituted.

Although use of a single daily dose of gentamicin has not been evaluated for the treatment of PID, it is efficacious in other analogous situations. Parenteral therapy can be discontinued 24 hours after a patient improves clinically; continuing oral therapy should consist of doxycycline 100 mg orally twice a day or clindamycin 450 mg orally four times a day to complete a total of 14 days of therapy. When tubo-ovarian abscess is present, many health-care providers use clindamycin for continued therapy rather than doxycycline, because clindamycin provides more effective anaerobic coverage.

Alternative Parenteral Regimens

Limited data support the use of other parenteral regimens, but the following three regimens have been investigated in at least one clinical trial, and they have broad spectrum coverage.

Ofloxacin 400 mg IV every 12 hours
OR
Levofloxacin 500 mg IV once daily
WITH OR WITHOUT
Metronidazole 500 mg IV every 8 hours
OR
Ampicillin/Sulbactam 3 g IV every 6 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours.

IV ofloxacin has been investigated as a single agent; however because of concerns regarding its spectum, metronidazole may be included in the regimen. Preliminary data suggest that levofloxacin is as effective as ofloxacin and may be substituted; its single daily dosing makes it advantageous from a compliance perspective (*83*). Ampicillin/sulbactam plus doxycycline has good coverage against *C. trachomatis, N. gonorrhoeae*, and anaerobes and is effective for patients who have tubo-ovarian abscess.

Oral Treatment

As with parenteral regimens, clinical trials of outpatient regimens have provided minimal information regarding intermediate and long-term outcomes. The following regimens provide coverage against the frequent etiologic agents of PID, but evidence from clinical trials supporting their use is limited. Patients who do not respond to oral therapy within 72 hours should be reevaluated to confirm the diagnosis and should be administered parenteral therapy on either an outpatient or inpatient basis.

Regimen A

Ofloxacin 400 mg orally twice a day for 14 days
OR
Levofloxacin 500 mg orally once daily for 14 days
WITH OR WITHOUT
Metronidazole 500 mg orally twice a day for 14 days.

Oral ofloxacin has been investigated as a single agent in two well-designed clinical trials, and it is effective against both *N. gonorrhoeae* and *C. trachomatis* (*84,85*). Despite the results of these trials, lack of anaerobic coverage with ofloxacin is a concern; the addition of metronidazole to the treatment regimen provides this coverage. Preliminary data suggest that levofloxacin is as effective as ofloxacin and may be substituted (*83*); its single daily dosing makes it advantageous from a compliance perspective.

Regimen B

Ceftriaxone 250 mg IM in a single dose
OR
Cefoxitin 2 g IM in a single dose and **Probenecid**, 1 g orally administered concurrently in a single dose
OR
Other parenteral third-generation **cephalosporin** (e.g., **ceftizoxime** or **cefotaxime**)
PLUS
Doxycycline 100 mg orally twice a day for 14 days
WITH or WITHOUT
Metronidazole 500 mg orally twice a day for 14 days.

The optimal choice of a cephalosporin for Regimen B is unclear; although cefoxitin has better anaerobic coverage, ceftriaxone has better coverage against *N. gonorrhoeae*. Clinical trials have demonstrated that a single dose of cefoxitin is effective in obtaining short-term clinical response in women who have PID; however, the theoretical limitations in its coverage of anaerobes may require the addition of metronidazole to the treatment regimen (*86*). The metronidazole also will effectively treat BV, which is frequently associated with PID. No data have been published regarding the use of oral cephalosporins for the treatment of PID. Limited data suggest that the combination of oral metronidazole plus doxycycline after primary parenteral therapy is safe and effective (*87,88*).

Alternative Oral Regimens

Although information regarding other outpatient regimens is limited, one other regimen has undergone at least one clinical trial and has broad spectrum coverage. Amoxicillin/clavulanic acid plus doxycycline was effective in obtaining short-term clinical response in a single clinical trial; however, gastrointestinal symptoms might limit compliance with this regimen. Several recent investigations have evaluated the use of azithromycin in the treatment of upper reproductive tract infections; however, the data are insufficient to recommend this agent as a component of any of the oral treatment regimens for PID.

Follow-Up

Patients should demonstrate substantial clinical improvement (e.g., defervescence; reduction in direct or rebound abdominal tenderness; and reduction in uterine, adnexal, and cervical motion tenderness) within 3 days after initiation of therapy. Patients who do not improve within this period usually require hospitalization, additional diagnostic tests, and surgical intervention.

If the health-care provider prescribes outpatient oral or parenteral therapy, a follow-up examination should be performed within 72 hours using the criteria for clinical improvement described previously. If the patient has not improved, hospitalization for parenteral therapy and further evaluation are recommended. Some specialists also recommend rescreening for *C. trachomatis* and *N. gonorrhoeae* 4–6 weeks after therapy is completed in women with documented infection with these pathogens.

Management of Sex Partners

Male sex partners of women with PID should be examined and treated if they had sexual contact with the patient during the 60 days preceding the patient's onset of symptoms. Evaluation and treatment are imperative because of the risk for reinfection of the patient and the strong likelihood of urethral gonococcal or chlamydial infection in the sex partner. Male partners of women who have PID caused by *C. trachomatis* and/or *N. gonorrhoeae* often are asymptomatic.

Sex partners should be treated empirically with regimens effective against both of these infections, regardless of the etiology of PID or pathogens isolated from the infected woman. Even in clinical settings in which only women are treated, arrangements should be made to provide care for male sex partners of women who have PID. When this is not feasible, health-care providers should ensure that sex partners are referred for appropriate treatment.

Prevention

Prevention of chlamydial infection by screening and treating high-risk women reduces the incidence of PID. Theoretically, most cases of PID can be prevented by screening all women or those determined to be at high-risk (based on age or other factors) using DNA amplification on cervical specimens (in women receiving pelvic exams) and on urine (in women not undergoing exams). Although BV is associated with PID, whether the incidence of PID can be reduced by identifying and treating women with BV is unclear.

Special Considerations

Pregnancy

Because of the high risk for maternal morbidity, fetal wastage, and preterm delivery, pregnant women who have suspected PID should be hospitalized and treated with parenteral antibiotics.

HIV Infection

Differences in the clinical manifestations of PID between HIV-infected women and HIV-negative women have not been well delineated. In early observational studies, HIV-infected women with PID were more likely to require surgical intervention. In recent, more comprehensive observational and controlled studies, HIV-infected women with PID had similar symptoms when compared with uninfected controls (*89–91*). They were more likely to have a tubo-ovarian abscess, but responded equally well to standard parenteral and oral antibiotic regimens when compared with HIV-negative women. The microbiologic findings for HIV-positive and HIV-negative women were similar, except for a) higher rates of concomitant *M. hominis*, candida, streptococcal, and HPV infections and b) HPV-related cytologic abnormalities among those with HIV infection. Whether the management of immunodeficient HIV-infected women with PID requires more aggressive interventions (e.g., hospitalization or parenteral antimicrobial regimens) has not been determined.

Epididymitis

Among sexually active men aged <35 years, epididymitis is most often caused by *C. trachomatis* or *N. gonorrhoeae*. Epididymitis caused by sexually transmitted enteric organisms (e.g., *Escherichia coli*) also occurs among men who are the insertive partner during anal intercourse. Sexually transmitted epididymitis usually is accompanied by urethritis, which often is asymptomatic. Nonsexually transmitted epididymitis that is associated with urinary-tract infections caused by Gram-negative enteric organisms occurs more frequently among men aged >35 years, men who have recently undergone urinary-tract instrumentation or surgery, and men who have anatomical abnormalities of the urinary tract.

Although most patients can be treated on an outpatient basis, hospitalization should be considered when severe pain suggests other diagnoses (e.g., torsion, testicular infarction, or abscess) or when patients are febrile or might be noncompliant with an antimicrobial regimen.

Diagnostic Considerations

Men who have epididymitis typically have unilateral testicular pain and tenderness; hydrocele and palpable swelling of the epididymis usually are present. Testicular torsion, a surgical emergency, should be considered in all cases, but it occurs more frequently among adolescents and in men without evidence of inflammation or infection. Emergency testing for torsion may be indicated when the onset of pain is sudden, pain is severe, or the test results available during the initial examination do not support a diagnosis of urethritis or urinary-tract infection. If the diagnosis is questionable, a specialist should be consulted immediately, because testicular viability may be compromised. The evaluation of men for epididymitis should include the following procedures.

- A Gram-stained smear of urethral exudate or intraurethral swab specimen for diagnosis of urethritis (i.e., ≥5 polymorphonuclear leukocytes per oil immersion field) and for presumptive diagnosis of gonococcal infection.
- A culture of intraurethral exudate or a nucleic acid amplification test (either on intraurethral swab or first-void urine) for *N. gonorrhoeae* and *C. trachomatis*.
- Examination of first-void uncentrifuged urine for leukocytes if the urethral Gram stain is negative. A culture and Gram-stained smear of this urine specimen should be obtained.
- Syphilis serology and HIV counseling and testing.

Treatment

Empiric therapy is indicated before culture results are available. Treatment of epididymitis caused by *C. trachomatis* or *N. gonorrhoeae* will result in a) microbiologic cure of infection, b) improvement of signs and symptoms, c) prevention of transmission to others, and d) a decrease in potential complications (e.g., infertility or chronic pain). As an adjunct to therapy, bed rest, scrotal elevation, and analgesics are recommended until fever and local inflammation have subsided.

Recommended Regimens

For epididymitis most likely caused by gonococcal or chlamydial infection:

Ceftriaxone 250 mg IM in a single dose

PLUS

Doxycycline 100 mg orally twice a day for 10 days.

For epididymitis most likely caused by enteric organisms, for patients allergic to cephalosporins and/or tetracyclines, or for epididymitis in patients aged >35 years:

Ofloxacin 300 mg orally twice a day for 10 days[§§]

OR

Levofloxacin 500 mg orally once daily for 10 days.[§§]

Follow-Up

Failure to improve within 3 days of the initiation of treatment requires reevaluation of both the diagnosis and therapy. Swelling and tenderness that persist after completion of antimicrobial therapy should be evaluated comprehensively. The differential diagnosis includes tumor, abscess, infarction, testicular cancer, TB, and fungal epididymitis.

Management of Sex Partners

Patients who have epididymitis that has been confirmed or is suspected to be caused by *N. gonorrhoeae* or *C. trachomatis* should be instructed to refer sex partners for evaluation and treatment. Sex partners of these patients should be referred if their contact with the index patient was within the 60 days preceding onset of the patient's symptoms.

Patients should be instructed to avoid sexual intercourse until they and their sex partners are cured (i.e., until therapy is completed and patient and partner[s] no longer have symptoms).

Special Considerations

HIV Infection

Patients who have uncomplicated epididymitis and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative. Fungi and mycobacteria, however, are more likely to cause epididymitis in immunosuppressed patients than in those who are immunocompetent.

Human Papillomavirus Infection

Genital Warts

More than 30 types of HPV can infect the genital tract. Most HPV infections are asymptomatic, unrecognized, or subclinical. Visible genital warts usually are caused by HPV types 6 or 11. Other HPV types in the anogenital region (e.g., types 16, 18, 31, 33, and 35) have been strongly associated with cervical neoplasia. Diagnosis of genital warts can be confirmed by biopsy, although biopsy is needed only under certain circumstances (e.g., if the diagnosis is uncertain; the lesions do not respond to standard therapy; the disease worsens during therapy; the patient is immunocompromised; or warts are pigmented, indurated, fixed, and ulcerated). No data support the use of type-specific HPV nucleic acid tests in the routine diagnosis or management of visible genital warts.

In addition to the external genitalia (i.e., the penis, vulva, scrotum, perineum, and perianal skin), genital warts can occur on the uterine cervix and in the vagina, urethra, anus, and mouth; these warts are sometimes symptomatic. Intra-anal warts are seen predominantly in patients who have had receptive anal intercourse; these warts are distinct from perianal warts, which can occur in men and women who do not have a history of anal sex. In addition to the genital area, HPV types 6 and 11 have been associated with conjunctival, nasal, oral, and laryngeal warts. HPV types 6 and 11 rarely are associated with invasive squamous cell carcinoma of the external genitalia. Depending on the size and anatomic location, genital warts can be painful, friable, and pruritic, although they are commonly asymptomatic.

HPV types 16, 18, 31, 33, and 35 are found occasionally in visible genital warts and have been associated with external genital (i.e., vulvar, penile, and anal) squamous intraepithelial neoplasia (i.e., squamous cell carcinoma in situ, bowenoid papulosis, Erythroplasia of Queyrat, or Bowen's disease of the genitalia). These HPV types also have been associated with vaginal, anal, and cervical intraepithelial dysplasia and squamous cell carcinoma. Patients who have visible genital warts can be infected simultaneously with multiple HPV types.

Treatment

The primary goal of treating visible genital warts is the removal of symptomatic warts. In most patients, treatment can induce wart-free periods. If left untreated, visible genital warts may resolve on their own, remain unchanged, or increase in size or number. Determining whether treatment of genital warts will reduce transmission is difficult, because no laboratory marker of infectivity has been established and because clinical studies evaluating the persistence of HPV DNA in genital tissue after treatment have shown variable results. Existing data indicate that currently available therapies for genital warts may reduce, but probably do not eradicate, infectivity. Whether the reduction in viral DNA that results from current treatment regimens impacts future transmission remains unclear. No evidence indicates that either the presence of genital warts or their treatment is associated with the development of cervical cancer.

Regimens

Treatment of genital warts should be guided by the preference of the patient, the available resources, and the experience of the health-care provider. No definitive evidence suggests that any of the available treatments is superior to the others, and no single treatment is ideal for all patients or all warts. The use of locally developed and monitored treatment algorithms has been associated with improved clinical outcomes and should be encouraged. Because of uncertainty regarding the effect of treatment on future transmission and the possibility for spontaneous resolution, an acceptable alternative for

some patients is to forego treatment and await spontaneous resolution.

Most patients have ≤10 genital warts, with a total wart area of 0.5–1.0 cm^2. These warts respond to most treatment modalities. Factors that may influence selection of treatment include wart size, wart number, anatomic site of wart, wart morphology, patient preference, cost of treatment, convenience, adverse effects, and provider experience. Many patients require a course of therapy rather than a single treatment. In general, warts located on moist surfaces and/or in intertriginous areas respond better to topical treatment than do warts on drier surfaces.

The treatment modality should be changed if a patient has not improved substantially after three provider-administered treatments or if warts have not completely cleared after six treatments. The risk-benefit ratio of treatment should be evaluated throughout the course of therapy to avoid overtreatment. Both patient-applied therapies and provider-administered therapies are available. Providers should be knowledgeable about, and have available to them, at least one patient-applied and one provider-administered treatment.

Complications rarely occur if treatments for warts are employed properly. Patients should be warned that persistent hypopigmentation or hyperpigmentation are common with ablative modalities. Depressed or hypertrophic scars are uncommon but can occur, especially if the patient has had insufficient time to heal between treatments. Rarely, treatment can result in disabling chronic pain syndromes (e.g., vulvodynia or hyperesthesia of the treatment site).

Recommended Regimens for External Genital Warts

Patient-Applied:

Podofilox 0.5% solution or gel. Patients should apply podofilox solution with a cotton swab, or podofilox gel with a finger, to visible genital warts twice a day for 3 days, followed by 4 days of no therapy. This cycle may be repeated, as necessary, for up to four cycles. The total wart area treated should not exceed 10 cm^2, and the total volume of podofilox should be limited to 0.5 mL per day. If possible, the health-care provider should apply the initial treatment to demonstrate the proper application technique and identify which warts should be treated. The safety of podofilox during pregnancy has not been established.

OR

Imiquimod 5% cream. Patients should apply imiquimod cream once daily at bedtime, three times a week for up to 16 weeks. The treatment area should be washed with soap and water 6–10 hours after the application. The safety of imiquimod during pregnancy has not been established.

Provider-Administered:

Cryotherapy with liquid nitrogen or cryoprobe. Repeat applications every 1–2 weeks.

OR

Podophyllin resin 10%–25% in a compound tincture of benzoin. A small amount should be applied to each wart and allowed to air dry. The treatment can be repeated weekly, if necessary. To avoid the possibility of complications associated with systemic absorption and toxicity, some specialists recommend that application be limited to ≤0.5 mL of podophyllin or an area of <10 cm^2 of warts per session. Some specialists suggest that the preparation should be thoroughly washed off 1–4 hours after application to reduce local irritation. The safety of podophyllin during pregnancy has not been established.

OR

Trichloroacetic acid (TCA) or Bichloroacetic acid (BCA) 80%–90%. A small amount should be applied only to warts and allowed to dry, at which time a white "frosting" develops. If an excess amount of acid is applied, the treated area should be powdered with talc, sodium bicarbonate (i.e., baking soda), or liquid soap preparations to remove unreacted acid. This treatment can be repeated weekly, if necessary.

OR

Surgical removal either by tangential scissor excision, tangential shave excision, curettage, or electrosurgery.

Alternative Regimens

Intralesional interferon

OR

Laser surgery.

For patient-applied treatments, patients must be able to identify and reach warts to be treated. Podofilox 0.5% solution or gel, an antimitotic drug that destroys warts, is relatively inexpensive, easy to use, safe, and self-applied by patients. Most patients experience mild/moderate pain or local irritation after treatment. Imiquimod is a topically active immune enhancer that stimulates production of interferon and other cytokines. Local inflammatory reactions are common with the use of imiquimod; these reactions usually are mild to moderate. Traditionally, follow-up visits are not required for patients using self-administered therapy. However, follow-up may be

useful several weeks into therapy to determine appropriateness of medication use and response to treatment.

Cryotherapy destroys warts by thermal-induced cytolysis. Health-care providers must be trained on the proper use of this therapy, because over- and under-treatment may result in poor efficacy or increased likelihood of complications. Pain after application of the liquid nitrogen, followed by necrosis and sometimes blistering, is common. Local anesthesia (topical or injected) may facilitate therapy if warts are present in many areas or if the area of warts is large.

Podophyllin resin, which contains several compounds including antimitotic podophyllin lignans, is another treatment option. The resin is most frequently compounded at 10%–25% in a tincture of benzoin. However, podophyllin resin preparations differ in the concentration of active components and contaminants. The shelf life and stability of podophyllin preparations are unknown. A thin layer of podophyllin resin must be applied to the warts and allowed to air dry before the treated area comes into contact with clothing; overapplication or failure to air dry can result in local irritation caused by spread of the compound to adjacent areas.

Both TCA and BCA are caustic agents that destroy warts by chemical coagulation of the proteins. Although these preparations are widely used, they have not been investigated thoroughly. TCA solutions have a low viscosity comparable with that of water and can spread rapidly if applied excessively; thus, they can damage adjacent tissues. Both TCA and BCA should be applied sparingly and allowed to dry before the patient sits or stands. If pain is intense, the acid can be neutralized with soap or sodium bicarbonate.

Surgical therapy is a treatment option that has the advantage of usually eliminating warts at a single visit. However, such therapy requires substantial clinical training, additional equipment, and a longer office visit. Once local anesthesia is applied, the visible genital warts can be physically destroyed by electrocautery, in which case no additional hemostasis is required. Care must be taken to control the depth of electrocautery to prevent scarring. Alternatively, the warts can be removed either by tangential excision with a pair of fine scissors or a scalpel or by curettage. Because most warts are exophytic, this can be accomplished with a resulting wound that only extends into the upper dermis. Hemostasis can be achieved with an electrosurgical unit or a chemical styptic (e.g., an aluminum chloride solution). Suturing is neither required nor indicated in most cases when surgical removal is done properly. Surgical therapy is most beneficial for patients who have a large number or area of genital warts. Carbon dioxide laser and surgery may be useful in the management of extensive warts or intraurethral warts, particularly for those patients who have not responded to other treatments.

Interferons, either natural or recombinant, used for the treatment of genital warts have been administered systemically (i.e., subcutaneously at a distant site or IM) and intralesionally (i.e., injected into the warts). Systemic interferon is not effective. The efficacy and recurrence rates of intralesional interferon are comparable to other treatment modalities. Interferon is likely effective because of its anti-viral and/or immunostimulating effects. However, interferon therapy is not recommended for routine use because of inconvenient routes of administration, frequent office visits, and the association between its use and a high frequency of systemic adverse effects.

Because of the shortcomings of all available treatments, some clinics employ combination therapy (i.e., the simultaneous use of two or more modalities on the same wart at the same time). However, some specialists believe that combining modalities may increase complications without improving efficacy.

Cervical Warts

For women who have exophytic cervical warts, high-grade squamous intraepithelial lesions (SIL) must be excluded before treatment is initiated. Management of exophytic cervical warts should include consultation with a specialist.

Recommended Regimens for Vaginal Warts

Cryotherapy with liquid nitrogen. The use of a cryoprobe in the vagina is not recommended because of the risk for vaginal perforation and fistula formation.

OR

TCA or BCA 80%–90% applied to warts. A small amount should be applied only to warts and allowed to dry, at which time a white "frosting" develops. If an excess amount of acid is applied, the treated area should be powdered with talc, sodium bicarbonate (i.e., baking soda), or liquid soap preparations to remove unreacted acid. This treatment can be repeated weekly, if necessary.

Recommended Regimens for Urethral Meatus Warts

Cryotherapy with liquid nitrogen

OR

Podophyllin 10%–25% in compound tincture of benzoin. The treatment area must be dry before contact with normal mucosa. This treatment can be repeated weekly, if necessary. The safety of podophyllin during pregnancy has not been established.

NOTE: Although data evaluating the use of podofilox and imiquimod for the treatment of distal meatal warts are limited, some specialists recommend their use in certain patients.

Recommended Regimens for Anal Warts

Cryotherapy with liquid nitrogen

OR

TCA or BCA 80%–90% applied to warts. A small amount should be applied only to warts and allowed to dry, at which time a white "frosting" develops. If an excess amount of acid is applied, the treated area should be powdered with talc, sodium bicarbonate (i.e., baking soda), or liquid soap preparations to remove unreacted acid. This treatment can be repeated weekly, if necessary.

OR

Surgical removal.

NOTE: Warts on the rectal mucosa should be managed in consultation with a specialist.

Recommended Regimens for Oral Warts

Cryotherapy with liquid nitrogen

OR

Surgical removal.

Education and counseling are important aspects of managing patients with genital warts. Patients can be educated through patient education materials, including pamphlets, hotlines, and web sites (http://www.ashastd.org). Attempts should be made to cover the following key messages.

- Genital HPV infection is a viral infection that is common among sexually active adults.
- Infection is almost always sexually transmitted, but the incubation period is variable and it is often difficult to determine the source of infection. Within ongoing relationships, sex partners usually are infected by the time of the patient's diagnosis, although they may have no symptoms or signs of infection.
- The natural history of genital warts is generally benign; the types of HPV that usually cause external genital warts are not associated with cancer. Recurrence of genital warts within the first several months after treatment is common and usually indicates recurrence rather than reinfection.
- The likelihood of transmission to future partners and the duration of infectivity after treatment are unknown. The use of latex condoms has been associated with a lower rate of cervical cancer, an HPV-associated disease.
- Because genital HPV is common among persons who have been sexually active and because the duration of infectivity is unknown, the value of disclosing a past diagnosis of genital HPV infection to future partners is unclear. Candid discussions about other STDs should be encouraged and attempted whenever possible.

Follow-Up

After visible genital warts have cleared, a follow-up evaluation is not mandatory but may be helpful. Patients should be cautioned to watch for recurrences, which occur most frequently during the first 3 months. Because the sensitivity and specificity of self-diagnosis of genital warts are unknown, patients concerned about recurrences should be offered a follow-up evaluation 3 months after treatment. Earlier follow-up visits also may be useful for some patients to document the absence of warts, to monitor for or treat complications of therapy, and to provide an additional opportunity for patient education and counseling. Women should be counseled to undergo regular Pap screening as recommended for women without genital warts. The presence of genital warts is not an indication for a change in the frequency of Pap tests or for cervical colposcopy.

Management of Sex Partners

Examination of sex partners is not necessary for the management of genital warts because no data indicate that reinfection plays a role in recurrences. Additionally, providing treatment solely for the purpose of preventing future transmission cannot be recommended because the value of treatment in reducing infectivity is not known. However, because self- or partner-examination has not been evaluated as a diagnostic method for genital warts, sex partners of patients who have genital warts may benefit from examination to assess the presence of genital warts and other STDs. The counseling of sex partners provides an opportunity for these partners to a) learn about implications of having a partner who has genital warts and about their potential for future disease transmission and b) receive STD and Pap screening. Female sex partners of patients who have genital warts should be reminded that cytologic screening for cervical cancer is recommended for all sexually active women.

Special Considerations

Pregnancy

Imiquimod, podophyllin, and podofilox should not be used during pregnancy. Because genital warts can proliferate and become friable during pregnancy, many specialists advocate their removal during pregnancy. HPV types 6 and 11 can cause respiratory papillomatosis in infants and children. The route of transmission (i.e., transplacental, perinatal, or postnatal) is not completely understood. The preventive value of cesarean

section is unknown; thus, cesarean delivery should not be performed solely to prevent transmission of HPV infection to the newborn. Cesarean delivery may be indicated for women with genital warts if the pelvic outlet is obstructed or if vaginal delivery would result in excessive bleeding.

Immunodeficient Patients

Persons who are immunosuppressed because of HIV or other reasons may not respond as well as immunocompetent persons to therapy for genital warts, and they may have more frequent recurrences after treatment. Squamous cell carcinomas arising in or resembling genital warts may occur more frequently among immunosuppressed persons, thus requiring biopsy for confirmation of diagnosis. Because of the increased incidence of anal cancer in HIV-infected homosexual men, screening for anal SIL by cytology in this population is advocated by some specialists. However, until more data about the natural history of anal SIL and treatment efficacy are available, such a screening approach is not recommended.

Squamous Cell Carcinoma in Situ

Patients in whom squamous cell carcinoma in situ of the genitalia is diagnosed should be referred to a specialist for treatment. Ablative modalities usually are effective, but careful follow-up is important. The risk for these lesions leading to invasive squamous cell carcinoma of the external genitalia in immunocompetent patients is unknown but is probably low. Female partners of male patients who have squamous cell carcinoma in situ are at high risk for cervical abnormalities.

Subclinical Genital HPV Infection (Without Exophytic Warts)

Subclinical genital HPV infection is a term often used to refer to manifestations of infection in the absence of genital warts, including situations where infection is detected on the cervix by Pap test, colposcopy, or biopsy; on the penis, vulva, or other genital skin by the appearance of white areas after application of acetic acid; or on any genital skin by a positive test for HPV.

Subclinical genital HPV infection occurs more frequently than visible genital warts among both men and women. Subclinical infection of the cervix is most commonly diagnosed by Pap screening with the detection of squamous intraepithelial lesions. The application of 3%–5% acetic acid usually turns HPV-infected genital mucosal tissue a whitish color. However, acetic acid application is not a specific test for HPV infection, and the specificity and sensitivity of this procedure for screening have not been defined. Thus, the routine use of this procedure for screening to detect subclinical infection is not recommended. However, some experienced clinicians find this test useful for identification of flat genital warts.

A definitive diagnosis of HPV infection is based on detection of viral nucleic acid (DNA or RNA) or capsid protein. Pap-test diagnosis of HPV does not always correlate with detection of HPV DNA in cervical cells. Cell changes attributed to HPV in the cervix are similar to those of SIL and often regress spontaneously without treatment. Tests that detect several types of HPV DNA in cells scraped from the cervix are available and may be useful in the triage of women with atypical squamous cells of undetermined significance (ASCUS) but not other types of cytologic abnormalities. Screening for subclinical genital HPV infection using DNA or RNA tests is not recommended.

Treatment

In the absence of coexistent SIL, treatment is not recommended for subclinical genital HPV infection diagnosed by colposcopy, biopsy, acetic acid application, or the detection of HPV by laboratory tests. The diagnosis of subclinical genital HPV infection is often not definitive, and no therapy has been identified that eradicates infection. In the presence of coexistent SIL, management should be based on histopathologic findings.

Management of Sex Partners

Examination of sex partners is unnecessary. Most sex partners of infected patients probably are already infected subclinically with HPV. No screening tests for subclinical infection are available. Likewise, whether patients who have subclinical HPV infection are as infectious as patients who have exophytic warts is unknown.

Cervical Cancer Screening for Women Who Attend STD Clinics or Have a History of STDs

Women with a history of STD may be at increased risk for cervical cancer, and women attending STD clinics may have other risk factors that place them at even greater risk. Prevalence studies have determined that precursor lesions for cervical cancer occur about five times more frequently among women attending STD clinics than among women attending family planning clinics (*92*). The cervical Pap test is an effective, low-cost screening test for preventing invasive cervical cancer. Recommendations regarding Pap testing intervals vary in the United States (*93,94,10*). However, if a woman has three consecutive negative annual Pap tests, future screening tests may be performed less frequently.

Recommendations

At the time of a pelvic examination for STD screening, the health-care provider should inquire about the result of the patient's last Pap test and discuss the following information with the patient:

- the purpose and importance of a Pap test;
- whether a Pap test was obtained during the clinic visit;
- the need for a regular Pap test; and
- if a Pap test was not obtained during this examination, the names of local providers or referral clinics that can obtain Pap tests and adequately follow up results.

If a woman has not had a Pap test during the previous 12 months, a Pap test may be obtained as part of the routine pelvic examination. Health-care providers should be aware that many women believe they have had a Pap test when they actually have received only a pelvic examination, and thus may report having had a recent Pap test. Therefore, in STD clinics, a Pap test should be strongly considered during the routine clinical evaluation of women who do not have clinical-record documentation of having had a normal Pap test within the preceding 12–36 months.

A woman may benefit from receiving printed information about Pap tests and a report containing a statement that a Pap test was obtained during her clinic visit. If possible, a copy of the Pap test result should be provided to the patient for her records.

Follow-Up

Clinicians who offer Pap test screening services are encouraged to use cytopathology laboratories that report results using the Bethesda System of classification[†††]. If the results of the Pap test are abnormal, care should be provided according to the *Interim Guidelines for Management of Abnormal Cervical Cytology* published by the National Cancer Institute Consensus Panel (*95*). Appropriate follow-up of Pap tests showing high-grade SIL always includes referral to a clinician who can provide a colposcopic examination of the lower genital tract and, if indicated, colposcopically directed biopsy. For patients who have a Pap test indicative of low-grade SIL or ASCUS, follow-up without colposcopy may be acceptable in some circumstances. Such follow-up would involve repeat Pap tests every 4–6 months for 2 years until the results of three consecutive tests are negative. If repeat tests show persistent abnormalities, colposcopy and directed biopsy may be indicated. However, if compliance with follow-up is in question, women with low-grade SIL or ASCUS may be considered for colposcopy. If specific infections other than HPV are identified, the patient should be reevaluated after appropriate treatment for those infections. In all follow-up strategies using repeat Pap tests, the tests not only must be negative but also must be interpreted by the laboratory as "satisfactory for evaluation." Tests determined by the laboratory to be "satisfactory but limited by…" in conjunction with a diagnosis of "negative" or "within normal limits" are also considered negative.

Another strategy for management of patients with ASCUS Pap tests involves testing for HPV DNA. If high-risk types of HPV DNA are detected, women with ASCUS tests are referred immediately for colposcopy. Because many public health clinics, including most STD clinics, cannot provide clinical follow-up of abnormal Pap tests, women with Pap tests demonstrating high grade SIL, persistent low-grade SIL, or ASCUS usually need a referral to other local health-care providers or clinics for colposcopy and biopsy. Clinics and health-care providers who offer Pap test screening services but cannot provide appropriate colposcopic follow-up of abnormal Pap tests should arrange referral to services in which a) a patient will be promptly evaluated and treated and b) the results of the evaluation will be reported to the referring clinic or health-care provider. Clinics and health-care providers should develop protocols that identify women who miss follow-up appointments so that these women can be scheduled for repeat Pap tests, and they should reevaluate such protocols routinely. Pap test results, type and location of follow-up appointments, and results of follow-up should be clearly documented in the clinic record. The establishment of colposcopy and biopsy services in local health departments, especially in circumstances where referrals are difficult and follow-up is unlikely, should be considered.

Other Management Considerations

Other considerations in performing Pap tests are as follows.

- The Pap test is not a screening test for STDs.
- If a woman is menstruating, a Pap test should be postponed, and the woman should be advised to have a Pap test at the earliest opportunity.
- The presence of a mucopurulent discharge should not delay the Pap test. The test can be performed after careful removal of the discharge with a saline-soaked cotton swab.
- Women who have external genital warts do not need to have Pap tests more frequently than women who do not have warts, unless otherwise indicated.
- The sequence of Pap testing in relation to other cervicovaginal specimens does not appear to influence Pap

[†††] The *Bethesda System for Reporting Cervical/Vaginal Cytologic Diagnoses* uses the terms "low-grade SIL" and "high-grade SIL" (*95*). Low-grade SIL encompasses cellular changes associated with HPV and mild dysplasia/cervical intraepithelial neoplasia 1 (CIN1). High-grade SIL includes moderate dysplasia/CIN2, severe dysplasia/CIN3, and carcinoma in situ/CIN3.

test results or their interpretation. Therefore, when other cultures or specimens are collected for STD diagnoses, the Pap test can be obtained last.

- Women who have had a hysterectomy do not require a routine Pap test unless the hysterectomy was performed as a result of cervical cancer or its precursor lesions. In this situation, women should be advised to continue follow-up with the physician(s) who provided health care at the time of the hysterectomy.
- Health-care providers who receive basic retraining on Pap-test collection and clinics that use simple quality assurance measures obtain fewer unsatisfactory tests. The use of cytobrushes also improves the number of satisfactory Pap tests.
- Emerging data support the option of HPV testing for the triage of women who have ASCUS Pap tests. However, experience is limited and studies to define its value and cost-effectiveness are ongoing. The HPV testing strategy may be most cost-effective when conducted as "reflex testing," in which samples collected at the initial visit can be tested for HPV after the Pap test results are available. This approach requires the collection of a cervical swab placed in liquid media (i.e., liquid-based cytology or collection of a separate swab stored in HPV transport media).
- Liquid-based cytology is an alternative to conventional Pap tests. It has a higher sensitivity for detection of SIL and can facilitate HPV testing in women with ASCUS. However, it may also have a lower specificity, resulting in more false-positive tests and more administrative and patient-related costs, which could reduce the cost-effectiveness of cervical cancer screening.

Special Considerations

Pregnancy

Pregnant women should have a Pap test as part of routine prenatal care. A cytobrush may be used for obtaining Pap tests in pregnant women, although care should be taken not to disrupt the mucous plug.

HIV Infection

Several studies have documented an increased prevalence of SIL in HIV-infected women (*96*). The following recommendations for Pap test screening among HIV-infected women are consistent with other guidelines published by the U.S. Department of Health and Human Services (*21*) and are based partially on the opinions of professionals knowledgeable in the care and management of cervical cancer and HIV infection in women.

After obtaining a complete history of previous cervical disease, HIV-infected women should be provided a comprehensive gynecologic examination, including a pelvic examination and Pap test, as part of their initial evaluation. A Pap test should be obtained twice in the first year after diagnosis of HIV infection and, if the results are normal, annually thereafter. If the results of the Pap test are abnormal, care should be provided according to the *Interim Guidelines for Management of Abnormal Cervical Cytology* (*97*). Women who have a cytological diagnosis of high-grade SIL or squamous cell carcinoma should undergo colposcopy and directed biopsy. HIV infection is not an indication for colposcopy in women who have normal Pap tests.

Vaccine Preventable STDs

The most effective means to prevent transmission of infectious diseases, including STDs, is through preexposure immunization. Vaccines are available for prevention of HAV and HBV, both of which can be transmitted sexually. Vaccines are under development or are undergoing clinical trials for other STDs, including HIV, HPV, and HSV; however, current efforts regarding vaccination focus largely on integrating use of currently available vaccines into STD prevention and treatment activities.

Every person seeking treatment for an STD should be considered a candidate for hepatitis B vaccination, and some persons (e.g., MSM and injection-drug users) should be considered for hepatitis A vaccination. Evaluation for vaccination is most effectively done through a screening and education process that both inquires about risk factors for infection (e.g., sex partners and use of illegal drugs), educates patients about the importance of vaccination, and excludes persons who are not candidates for vaccination (e.g., laboratory confirmed diagnosis of infection and previous vaccination).

Although it is uncommon, patients may present with signs, symptoms, or laboratory findings of acute or chronic viral hepatitis. When this occurs, a precise diagnosis must be made and appropriate clinical services provided, including postexposure immunization of contacts and medical referral.

Hepatitis A

Hepatitis A, caused by infection with HAV, has an incubation period from time of exposure to onset of symptoms of approximately 4 weeks (range: 15–50 days). HAV replicates in the liver and is shed in high concentrations in feces from 2 weeks before to 1 week after the onset of clinical illness. HAV is most commonly transmitted by the fecal-oral route.

Although viremia occurs early in infection and can persist for several weeks after onset of symptoms, bloodborne transmission of HAV is uncommon.

HAV infection produces a self-limited disease that does not result in chronic infection or chronic liver disease. However, 10%–15% of patients may experience a relapse of symptoms during the 6 months after acute illness. Acute liver failure from hepatitis A is rare (0.3% overall case-fatality rate), but occurs more frequently in older persons (1.8% case fatality rate in adults >50 years of age) and persons with underlying chronic liver disease. The risk for symptomatic infection is directly related to age, with >80% of adults having symptoms compatible with acute viral hepatitis and most children having either asymptomatic or unrecognized infection. Antibody produced in response to HAV infection persists for life and confers protection against reinfection.

Approximately 33% of the U.S. population has serologic evidence of prior HAV infection, which increases directly with age and reaches 75% among persons aged >70 years. Most cases of hepatitis A result from person-to-person transmission during community-wide outbreaks. The most frequently reported source of infection (12%–26%) is either household or sexual contact with a person who had hepatitis A. In addition, outbreaks regularly occur among users of injection and non-injection drugs and among MSM. In the United States, up to 10% of reported cases of HAV occur among persons reporting these behaviors. Approximately 50% of persons with hepatitis A do not have an identified source for their infection.

Hepatitis A, like other enteric infections, can be transmitted during sexual activity. Recent outbreaks of hepatitis A among MSM have occurred in urban areas in the United States. Although some studies have associated having a greater number of sex partners, frequent oral-anal contact, insertive anal intercourse, or serologic evidence of other STDs with HAV infection, other studies have not found specific risk factors for infection.

Unlike persons with most other STDs, HAV-infected persons are infectious for only a relatively brief period of time. However, many sexual practices facilitate fecal-oral transmission of HAV, and inapparent fecal contamination is commonly present during sexual intercourse. Measures typically used to prevent the transmission of other STDs (e.g., use of condoms) do not prevent HAV transmission, and maintenance of "good personal hygiene" has not been successful in interrupting outbreaks of hepatitis A. Vaccination is the most effective means of preventing HAV transmission among persons at risk for sexual transmission of this virus and among persons who use injection and non-injection illegal drugs, many of whom may seek services in STD clinics.

Diagnosis

The diagnosis of hepatitis A cannot be made on clinical grounds alone and requires serologic testing, which is available commercially. The presence of IgM antibody to HAV is diagnostic of acute HAV infection. A positive test for total anti-HAV indicates immunity to HAV infection but does not differentiate acute from past HAV infection. Tests can be positive after hepatitis A vaccination.

Treatment

Patients with hepatitis A usually require only supportive care, with no restrictions in diet or activity. Hospitalization may be necessary for patients who become dehydrated because of nausea and vomiting and for patients with signs or symptoms of acute liver failure. Medications that might cause liver damage or are metabolized by the liver should be used with caution among persons with HAV.

Prevention

Two products are available for the prevention of hepatitis A: hepatitis A vaccine (Table 2) and immune globulin (IG) for IM administration (*2*). Inactivated hepatitis A vaccines are prepared from formalin-inactivated, cell-culture-derived HAV and have been available in the United States since 1995 for persons aged >2 years. Administered in a two-dose series, these vaccines induce protective antibody levels in virtually all adults. By 1 month after the first dose, 94%–100% of adults have protective antibody levels; 100% of adults develop protective antibody following a second dose. In randomized controlled trials, the equivalent of one dose of hepatitis A vaccine administered before exposure has been 94%–100% effective in preventing clinical hepatitis A (*3*). Kinetic models of antibody decline indicate that protective levels of antibody persist for at least 20 years.

A combined hepatitis A and B vaccine has been developed for adults. When administered on a 0-, 1-, 6-month schedule, the vaccine has equivalent immunogenicity to that of the monovalent vaccines.

TABLE 2. Recommended regimens: dose and schedule for hepatitis A vaccines

Vaccine	Age (years)	Dose*	Volume (mL)	Two-dose schedule (months)†
HAVRIX§	2–18	720 (EL.U.)	.05	0, 6–12
	>18	1,440 (EL.U.)	1.0	0, 6–12
VAQTA¶	2–18	25 (U)	0.5	0, 6–18
	>18	50 (U)	1.0	0, 6–12

* EL.U=Enzyme-linked immunosorbent assay (ELISA) units; U=Units.
† 0 months represents timing of the initial dose; subsequent numbers represent months after the initial dose.
§ Hepatitis A vaccine, inactivated, SmithKline Beecham Biologicals.
¶ Hepatitis A vaccine, inactivated, Merck & Co., Inc.

IG is a sterile solution of concentrated immunoglobulins prepared from pooled human plasma processed by cold ethanol fractionation. In the United States, IG is produced only from plasma that has tested negative for HBV, antibody to HIV, and antibody to HCV. In addition, the manufacturing process must either include a viral inactivation step or the final product must test negative for HCV RNA. When administered before or within 2 weeks after exposure to HAV, IG is ≥85% effective in preventing hepatitis A.

Preexposure Immunization

Persons in the following groups should be offered hepatitis A vaccine:

- MSM, including those who report having minimal or no current sexual activity;
- illegal drug users (both injection and non-injection drug users); and
- persons with chronic liver disease, including persons with chronic HBV and HCV infection who have evidence of chronic liver disease.

Hepatitis A vaccine currently is available for children and adolescents aged <19 years through the Vaccines for Children (VFC) program (tel: 800-232-2522).

Prevaccination Serologic Testing for Susceptibility

Screening for HAV infection may be cost-effective in populations where the prevalence of infection is likely to be high (e.g., older persons and persons born in areas of high HAV endemicity). The potential cost-savings of testing should be weighed against the likelihood that testing will interfere with initiating vaccination. Vaccination of a person who is already immune is not harmful.

Postvaccination Serologic Testing

Postvaccination serologic testing is not indicated because most persons respond to vaccine. In addition, the commercially available serologic test is not sensitive enough to detect the low, but protective, levels of antibody produced by vaccination.

Postexposure Prophylaxis

Previously unvaccinated persons exposed to HAV (e.g., through household or sexual contact or by sharing illegal drugs with a person who has hepatitis A) should be administered a single IM dose of IG (0.02 mL/kg) as soon as possible, but not >2 weeks after exposure. Persons who have had one dose of hepatitis A vaccine at least 1 month before exposure to HAV do not need IG. If hepatitis A vaccine is recommended for a person receiving IG, it can be administered simultaneously at a separate anatomic injection site. The use of hepatitis A vaccine alone is not recommended for postexposure prophylaxis.

Special Considerations

Limited data indicate that vaccination of HIV-infected persons results in lower seroprotection rates and antibody concentrations (*3*). Antibody response may be directly related to CD4+ levels.

Hepatitis B

Hepatitis B is caused by infection with HBV. The incubation period from time of exposure to onset of symptoms is 6 weeks to 6 months. HBV is hepatotropic, is found in highest concentrations in the blood, and is found in lower concentrations in other body fluids (e.g., semen, vaginal secretions, and wound exudates). HBV infection can be self-limited or chronic. In adults, only 50% of acute HBV infections are symptomatic, and about 1% of cases result in acute liver failure and death. Risk for chronic infection is associated with age at infection: about 90% of infected infants and 60% of infected children aged <5 years become chronically infected compared with 2%–6% of adults. Among persons with chronic HBV infection, the risk of death from cirrhosis or hepatocellular carcinoma is 15%–25%.

In the United States, an estimated 181,000 persons were infected with HBV in 1998, and about 5,000 deaths occurred from HBV-related cirrhosis or hepatocellular carcinoma. An estimated 1.25 million people are chronically infected with HBV, serve as a reservoir for infection, and are at increased risk for death from chronic liver disease.

HBV is efficiently transmitted by percutaneous or mucous membrane exposure to infectious body fluids. Sexual transmission among adults accounts for most HBV infections in the United States. In the 1990s, transmission among heterosexual partners accounted for about 40% of infections, and transmission among MSM accounted for another 15% of infections. The most common risk factors for heterosexual transmission include having multiple sex partners (i.e., more than one partner in a 6-month period) or a recent history of an STD. Risk factors for infection among MSM include having multiple sex partners, engaging in unprotected receptive anal intercourse, and having a history of other STDs. Changes in sexual practices among MSM to prevent HIV infection have resulted in a lower risk for HBV infection than that observed in the late 1970s, when studies found up to 70% prevalence of HBV markers among adult MSM. Recent surveys of young MSM (aged 15–22 years) indicated that 6%–13% of participants had evidence of HBV infection, whereas

3%–27% had evidence of having been immunized against hepatitis B (*98*).

Among persons with acute hepatitis B, up to 70% have previously received care in settings where they could have been vaccinated (e.g., STD clinics, drug treatment programs, and correctional facilities). A 1997 survey of STD clinics demonstrated that hepatitis B vaccine was routinely offered in only 5% of these settings.

Diagnosis

The diagnosis of acute or chronic HBV infection cannot be made on clinical grounds, but requires serologic testing (Table 3). Hepatitis B surface antigen (HBsAg) is present in either acute or chronic infection. The presence of IgM antibody to hepatitis B core antigen (IgM anti-HBc) is diagnostic of acute HBV infection. Antibody to HBsAg (anti-HBs) is produced following a resolved infection and is the only HBV antibody marker present following immunization. The presence of HBsAg with a negative test for IgM anti-HBc is indicative of chronic HBV infection. The presence of anti-HBc may indicate either acute, resolved, or chronic infection.

Treatment

Laboratory testing should be used to confirm suspected acute or chronic HBV infection, and infected persons should be referred for medical follow-up and possible treatment of chronic infection. In addition, contacts should be vaccinated (see Exposure to Persons who have Acute Hepatitis B) and receive postexposure prophylaxis. No specific therapy is available for persons with acute HBV infection; treatment is supportive.

Antiviral agents (i.e., alpha-interferon or lamivudine) are available for treatment of persons with chronic hepatitis B. To determine the likelihood of response to treatment, an initial evaluation is required to determine the status of the chronic HBV infection and the extent of liver disease. For this reason, treatment should be offered by health-care professionals with experience in the treatment of hepatitis B.

Prevention

Two products have been approved for hepatitis B prevention: hepatitis B immune globulin (HBIG) and hepatitis B vaccine. HBIG is prepared from plasma known to contain a high titer of anti-HBs and is used for postexposure prophylaxis. The recommended dose of HBIG for children and adults is 0.06 mL/kg. The dose is 0.5 mL to prevent perinatal HBV infection among infants born to HBsAg-positive mothers.

Hepatitis B vaccine uses HBsAg produced in yeast by recombinant DNA technology and provides protection from HBV infection when used for both preexposure immunization and postexposure prophylaxis. The two available monovalent hepatitis B vaccines for use in adolescents and adults are Recombivax HB® (Merck and Co., Inc.) and Engerix-B (SmithKline Beecham Biologicals).

The recommended vaccine dose varies by product and age of recipient (Table 4). Vaccine should be administered IM in the deltoid muscle and can be administered simultaneously with other vaccines. Many vaccination schedules have been used for both adults and adolescents. A two-dose schedule has been approved for adolescents aged 11–15 years using the adult dose of Recombivax HB®. If the vaccination series is interrupted after the first or second dose of vaccine, the missed dose should be administered as soon as possible. The series does not need to be restarted if a dose has been missed.

TABLE 3. Serologic markers in different stages of hepatitis B virus (HBV) infection

Stages of HBV infection	HbsAg*	Anti-HBs†	Anti-HBc§	Total¶ IgM
Late incubation period	+	-	-	+/-
Acute	+	-	+	+
Chronic	+	- (+ rarely)	+	-
Recent (<6 months) window period	-	+/-	+	+
Distant (>6 months); resolved**	-	+	+	-
Immunized	-	+††	-	-

* Hepatitis B surface antigen.
† Antibodies to hepatitis B surface antigen.
§ Antibodies to hepatitis B core antigen.
¶ The total anti-HBc assay detects both IgM and IgG antibody.
** "Resolved" indicates that the patient no longer has the disease.
†† Anti-HBs >10mIU/mL.

TABLE 4. Recommended regimen: doses and schedules of currently licensed hepatitis B vaccines for adolescents and adults

Group	Recombivax HB dose (µg)	Recombivax HB dose (mL)	Engerix-B dose (µg)	Engerix-B dose (mL)	Schedule (months)
Adolescents (aged 11–19 years)†	5*	0.5	10*	0.5	0, 1, 6, or 0, 2, 4, or 0, 1, 4, or 0, 12, 24
Adolescents (aged 11–15 years)†	10§	1.0			0, 4
Adults (aged ≥20 years)	10§	1.0	20§	1.0	0, 1, 6, or 0, 2, 4, or 0, 1, 4, or 0, 1, 2, 12¶

* Pediatric formulation.
† Eligible persons aged <19 years can receive free vaccine under the Vaccines for Children (VFC) program.
§ Adult formulation.
¶ This schedule has been used for persons requiring rapid protection (e.g., international travelers).

In adolescents and healthy adults aged <40 years, approximately 50% develop a protective antibody response (anti-HBs >10 mIU/mL) after the first vaccine dose, 70% after the second, and >90% after the third dose. Because relatively high rates of protection are achieved following each vaccine dose, hepatitis B vaccination should be initiated even if completion of the series cannot be ensured. Because most fully vaccinated persons have long-lasting protection from HBV infection, periodic testing to determine antibody levels in immune competent persons is not necessary, and booster doses of vaccine are not recommended.

Hepatitis B vaccine has been shown to be safe; more than 20 million adolescents and adults have been vaccinated in the United States. The vaccine is well tolerated by most recipients. Pain at the injection site or low grade fever are reported by a minority of recipients. Anaphylaxis is estimated to occur in one in 600,000 doses of vaccine administered; no deaths have been reported following anaphylaxis. Hepatitis B vaccine has not been associated with multiple sclerosis, diabetes, or other autoimmune or neurologic diseases in any controlled epidemiologic study. Vaccine is contraindicated in persons with a history of anaphylaxis after a previous dose of hepatitis B vaccine and in persons with a known anaphylactic reaction to yeast.

CDC's national immunization strategy to eliminate transmission of HBV infection includes a) prevention of perinatal infection through maternal HBsAg screening and postexposure prophylaxis of at-risk infants, b) universal infant immunization, c) universal immunization of previously unvaccinated adolescents aged 11–12 years (*99*), and d) vaccination of adolescents and adults at increased risk for infection (*100*). Although high immunization coverage rates have been achieved among infants and younger adolescents, hepatitis B incidence rates remain high because most infections now occur in adults. Although the cost of vaccine remains a barrier to adult vaccination, vaccine purchase and provider reimbursement should not be a barrier for vaccination of adolescents aged <19 years, who may be eligible for free vaccine under the Vaccines for Children (VFC) program (tel: 800-232-2522).

Preexposure Immunizations

Hepatitis B vaccine is recommended for all persons who attend STD clinics who have not been previously vaccinated. In the non-STD clinic setting, the following persons should be vaccinated: a) persons with history of an STD, persons who have had multiple sex partners, those who have had sex with an injection-drug user, and sexually active MSM; b) persons engaging in illegal drug use; c) household members, sex partners, and drug-sharing partners of a person with chronic HBV infection; and d) persons on hemodialysis, persons receiving clotting factor concentrates, or persons who have occupational exposure to blood. In addition, hepatitis B vaccine should be offered to all persons who have not been previously vaccinated who receive services in drug treatment programs and long-term correctional facilities.

Prevaccination Antibody Screening

Based on the current cost of hepatitis B vaccine, revaccination serologic testing may be cost-effective in adult populations with a high prevalence of HBV infection (>2% HBsAg positive or >30% anti-HBc positive). However, prevaccination testing is not cost-effective in any adolescent populations. Adult populations with high prevalence of HBV infection include injection-drug users, MSM, sexual contacts of persons with chronic HBV infection, and persons from countries with endemic HBV infection. When testing is performed, anti-HBc is the test of choice. Testing should not be a barrier to vaccination of susceptible persons, especially in populations that are difficult to access, and the first dose of vaccine should be administered at the same time that serologic testing is initiated.

As hepatitis B vaccination becomes more widespread, more persons will present with a history of vaccination and most will not have a personal vaccination record. However, serologic testing in persons with a history of previous hepatitis B vaccination may not be helpful because of the loss of detectable antibody. Without a vaccination record, obtaining a careful history (e.g., number of doses, schedule, and age at immunization) is the only way to determine if the person most likely received the complete hepatitis B vaccine series. Administration of additional doses of vaccine beyond the three-dose series is not harmful.

Postexposure Prophylaxis

Exposure to Persons Who Have Acute Hepatitis B

Sex Contacts. Previously unvaccinated sex partners of persons with acute hepatitis B should receive postexposure immunization with HBIG and hepatitis B vaccine within 14 days after the most recent sexual contact. HBIG has been shown to be required for effective postexposure protection in this setting. Administration of vaccine with HBIG in this setting confers long-term protection in the event the person with acute hepatitis B becomes chronically infected; simultaneous administration of HBIG and hepatitis B vaccine does not reduce vaccine effectiveness. Testing sex partners for susceptibility to HBV infection (anti-HBc) can be considered if it does not delay postexposure immunization beyond 14 days.

Nonsexual Household Contacts. Nonsexual household contacts of patients who have acute hepatitis B are not at increased risk for infection unless they have other risk factors or are exposed to the patient's blood (e.g., by sharing a toothbrush or razor blade). However, vaccination of household contacts

is encouraged, especially for children and adolescents. If the patient with acute hepatitis B becomes chronically infected (i.e., remains HBsAg-positive after 6 months), all household contacts should be vaccinated.

Exposure to Persons Who Have Chronic HBV Infection

Most HBsAg-positive persons are identified during routine screening (e.g., blood donation and prenatal evaluation) or clinical evaluation. Active postexposure prophylaxis with hepatitis B vaccine alone is recommended for sex or needle-sharing partners and non-sexual household contacts of persons with chronic HBV infection. Because identifying the time of the last contact can be difficult, hepatitis B vaccination provides both preexposure and postexposure protection. Although the effectiveness of active postexposure immunization has not been evaluated for sex contacts of persons with chronic HBV infection, it provides high-level protection (90%) against perinatal HBV infection, where the intensity of exposure is greater than that among household or sex contacts of chronically infected persons.

Postvaccination testing (anti-HBs) should be considered for sex partners of persons with chronic HBV infection. Although most persons are expected to respond to vaccination, those found to be antibody-negative should receive a second, complete vaccination series. Those persons found to be antibody-negative after revaccination should be counseled about abstinence and the use of other methods to protect themselves from sexual HBV transmission.

Special Considerations

Pregnancy

All pregnant women receiving STD services should be tested for HBsAg, regardless of whether they have been previously tested. If positive, this test result should be reported to state perinatal immunization or HBV prevention programs to ensure proper case management of the mother and appropriate postexposure immunization of her at-risk infant. HBsAg-negative pregnant women seeking STD treatment who have not been previously vaccinated should receive hepatitis B vaccine, as pregnancy is not a contraindication to vaccination.

HIV Infection

HBV infection in HIV-infected persons is more likely to result in chronic HBV infection. HIV infection also can impair the response to hepatitis B vaccine. Therefore, HIV-infected persons who are vaccinated should be tested for anti-HBs 1–2 months after the third vaccine dose. Revaccination with three more doses should be considered for persons who do not respond initially to vaccination. Those who do not respond to additional doses should be advised that they might remain susceptible to HBV infection and should be counseled in the use of methods to prevent HBV infection.

Victims of Sexual Assault

Studies have not determined the frequency with which HBV infection occurs following sexual abuse or rape. Fully vaccinated victims of sexual assault are protected from HBV infection and do not need further doses. For a victim who is not fully vaccinated, the vaccine series should be completed as scheduled. Unvaccinated persons in this setting should be administered active postexposure prophylaxis (i.e., vaccine alone) upon the initial clinical evaluation. Unless the offender is known to have acute hepatitis B, HBIG is not required.

Because sexual abuse of children frequently occurs over a prolonged period of time, the last exposure is often difficult to determine. However, when sexual abuse is identified, hepatitis B vaccination should be initiated in previously unvaccinated children.

Hepatitis C

HCV infection is the most common chronic bloodborne infection in the United States; an estimated 2.7 million persons are chronically infected (*101*). More than two thirds of all infected persons are aged <50 years. Persons with acute HCV infection typically are either asymptomatic or have a mild clinical illness. The average time from exposure to seroconversion is 8–9 weeks, and antibodies to HCV (anti-HCV) can be detected in >97% of persons by 6 months after exposure. Chronic HCV infection develops in most persons (75%–85%) after acute infection; 60%–70% have evidence of active liver disease. Most infected persons may not be aware of their infection because they are not clinically ill. However, infected persons serve as a source of transmission to others and are at risk for chronic liver disease or other HCV-related chronic diseases for at least 2 decades after infection.

HCV is most efficiently transmitted by direct percutaneous exposure to infected blood (e.g., by receipt of blood transfusion from an infected donor or through use of injection drugs). Although less efficient, occupational, perinatal, and sexual exposures also can result in transmission of HCV. No association has been documented between HCV and military service or HCV and exposures resulting from medical, dental, or surgical procedures; tattooing; acupuncture; ear piercing; or foreign travel (*102*).

The greatest variation in prevalence of HCV infection occurs among persons with different risk factors for infection. The highest prevalence of infection is found among those with

substantial or repeated direct percutaneous exposures to blood (e.g., IDUs, persons with hemophilia treated with clotting factor concentrates produced before 1987, and recipients of transfusions from HCV-positive donors). Moderate prevalence is found among persons with frequent but limited direct percutaneous exposures (e.g., long-term hemodialysis patients). Lower prevalence occurs among persons with inapparent percutaneous or mucosal exposures or sexual exposure and among those with limited, sporadic percutaneous exposures (e.g., health-care workers). Lowest prevalence of HCV infection is found among persons with no high-risk characteristics (e.g., blood donors).

Sexual Activity

Although the role of sexual activity in the transmission of HCV remains controversial, results from several types of studies indicate that sexual activity is associated with HCV transmission (*103,104*). These studies reported independent associations between HCV infection and a) exposure to an infected sex partner, b) increasing numbers of partners, c) failure to use a condom, d) history of STD, e) heterosexual sex with a male IDU, and f) sexual activities involving trauma.

In contrast, a low prevalence (average: 1.5%; range: 0%–4.4%) of HCV infection has been demonstrated in studies of long-term spouses of patients with chronic HCV infection who had no other risk factors for infection. One study has found an association between HCV infection and male homosexual activity, and at least in STD clinic settings, the prevalence rate of HCV infection among MSM generally has been similar to that of heterosexuals (*105*). Because sexual transmission of bloodborne viruses is more efficient among homosexual men compared with heterosexual men and women, it is unclear why HCV infection rates are not substantially higher among MSM compared with heterosexuals. This observation and the low prevalence of HCV infection observed among the long-term steady sex partners of persons with chronic HCV infection have raised doubts about the importance of sexual activity in the transmission of HCV. Unacknowledged percutaneous exposures (i.e., illegal injection-drug use) might contribute to increased risk for HCV infection among such persons.

Although inconsistencies exist between studies, data indicate overall that sexual transmission of HCV can occur and accounts for up to 20% of HCV infections (*102*). The substantial contribution of sexual transmission to the disease burden in the United States relative to the inefficiency with which the virus appears to be spread in this manner can be explained. Because sexual activity with multiple partners is a common behavior among chronically infected persons and because of the substantial number of these persons, multiple exposure opportunities exist. However, more data are needed to determine the risk for, and factors related to, transmission of HCV between sex partners, including whether other STDs promote the transmission of HCV by influencing viral load or modifying mucosal barriers.

Increased HCV viral load or coinfection with HIV (known to increase perinatal transmission of HCV) may increase the risk for sexual transmission. A recent study involving hemophilic men demonstrated that dually infected men had a higher HCV load than those infected with HCV alone, and that a higher HCV load was associated, though not significantly, with an increased risk for HCV transmission to female partners (*106*).

Diagnosis and Treatment

The diagnosis of HCV infection can be made by detecting either anti-HCV or HCV RNA. Anti-HCV is recommended for routine testing of asymptomatic persons and should include use of both EIA to test for anti-HCV and a supplemental antibody test (i.e., recombinant immunoblot assay [RIBA]) for all positive anti-HCV results. In settings where clinical services for liver disease are provided, use of reverse transcriptase polymerase chain reaction (RT-PCR) to detect HCV RNA might be appropriate to confirm the diagnosis of HCV infection (e.g., in patients with abnormal alanine aminotransferase [ALT] levels or with indeterminant supplemental anti-HCV test results), although RT-PCR assays are not currently FDA-approved.

Current approved therapy for HCV-related chronic liver disease includes alpha interferon alone or in combination with the oral agent ribavirin for a duration of 6–12 months. Because of advances in the field of antiviral therapy for chronic hepatitis C, standards of practice might change, and clinicians should consult with specialists knowledgeable about this virus. The National Institutes of Health Consensus Development Conference Panel recommended that therapy for hepatitis C be limited to those patients with persistently elevated ALT levels, detectable HCV RNA, and histologic evidence of progressive disease (as characterized by liver biopsy findings indicating either portal or bridging fibrosis or at least moderate degrees of inflammation and necrosis).

Prevention

No vaccine for hepatitis C is available, and prophylaxis with immune globulin is not effective in preventing HCV infection after exposure. Reducing the burden of HCV infection

and disease in the United States requires implementation of both primary and secondary prevention activities. Primary prevention reduces or eliminates HCV transmission; secondary prevention activities reduce liver and other chronic diseases in HCV-infected persons by identifying them and providing appropriate medical management and antiviral therapy, if necessary (*102*). Persons seeking care in STD clinics or other primary-care settings should be screened for risk factors for HCV infection, and those with the following risk factors should be offered counseling and testing:

- illegal injection drug use, even once or twice many years ago;
- blood transfusion or solid organ transplant before July 1992;
- receipt of clotting factor concentrates produced before 1987; and
- long-term hemodialysis.

Regardless of test results, persons who use illegal drugs or have multiple sex partners should be provided with information regarding how to reduce their risk for acquiring bloodborne and sexually transmitted infections and how to avoid transmitting infectious agents to others (e.g., through vaccination against hepatitis B and, if appropriate, hepatitis A). Persons who inject drugs should be counseled to stop using and get into a treatment program. If they are found at any follow-up visit to be continuing the use of these drugs, they should be counseled on how to inject safely (i.e., use of sterile, single-use equipment, including needles, syringes, cookers, cottons, and water each and every time they inject). Persons with multiple sex partners should be counseled regarding how to reduce the transmission of STDs (e.g., through abstinence or by decreasing the number of sex partners).

Persons who test negative for HCV who had a previous exposure should be reassured that they have not been exposed. Persons who test positive for HCV infection should be provided information regarding how to protect their liver from further harm, how to prevent transmission to others, and the need for medical evaluation for chronic liver disease (CLD) and possible treatment. To protect their liver from further harm, HCV-positive persons should be advised to avoid alcohol, avoid taking any new medicines (including over-the-counter and herbals) without checking with their doctor, and become vaccinated against hepatitis A or hepatitis B if they are not immune. To reduce the risk for transmission to others, HCV-positive persons should be advised not to donate blood, body organs, other tissue, or semen and not to share any personal items that may have blood on them (e.g., toothbrushes and razors).

HCV-positive persons with one long-term, steady sex partner do not need to change their sexual practices. They should discuss the low but present risk for transmission with their partner and discuss the need for counseling and testing. HCV-positive women do not need to avoid pregnancy or breastfeeding.

Postexposure Follow-Up

No postexposure prophylaxis is effective against HCV. Testing to determine whether HCV infection has developed is recommended for health-care workers after percutaneous or permucosal exposures to HCV-positive blood and for children born to HCV-positive women.

Proctitis, Proctocolitis, and Enteritis

Sexually transmitted gastrointestinal syndromes include proctitis, proctocolitis, and enteritis. Evaluation for these syndromes should include appropriate diagnostic procedures (e.g., anoscopy or sigmoidoscopy, stool examination, and culture).

Proctitis is inflammation limited to the rectum (the distal 10–12 cm) that may be associated with anorectal pain, tenesmus, or rectal discharge. *N. gonorrhoeae*, *C. trachomatis* (including LGV serovars), *T. pallidum*, and HSV are the most common sexually transmitted pathogens involved. In patients coinfected with HIV, herpes proctitis may be especially severe. Proctitis occurs predominantly among persons who participate in receptive anal intercourse.

Proctocolitis is associated with symptoms of proctitis plus diarrhea or abdominal cramps and inflammation of the colonic mucosa extending to 12 cm above the anus. Fecal leukocytes may be detected on stool examination depending on the pathogen. Pathogenic organisms include *Campylobacter* sp., *Shigella* sp., *Entamoeba histolytica*, and, rarely, LGV serovars of *C. trachomatis*. CMV or other opportunistic agents may be involved in immunosuppressed HIV-infected patients. Proctocolitis can be acquired by the oral route or by oral-fecal contact, depending on the pathogen.

Enteritis usually results in diarrhea and abdominal cramping without signs of proctitis or proctocolitis; it occurs among persons whose sexual practices include oral-fecal contact. In otherwise healthy persons, *Giardia lamblia* is most frequently implicated. When outbreaks of gastrointestinal illness occur among social or sexual networks of MSM, clinicians should consider sexual transmission as a mode of spread and counsel accordingly. Among HIV-infected patients, gastrointestinal illness can be caused by other infections that usually are not sexually transmitted, including CMV, *Mycobacterium avium-*

intracellulare, *Salmonella* sp., *Campylobacter* sp., *Shigella* sp., *Cryptosporidium*, *Microsporidium*, and *Isospora*. Multiple stool examinations may be necessary to detect *Giardia*, and special stool preparations are required to diagnose cryptosporidiosis and microsporidiosis. Additionally, enteritis may be directly caused by HIV infection.

When laboratory diagnostic capabilities are available, treatment decisions should be based on the specific diagnosis. Diagnostic and treatment recommendations for all enteric infections are beyond the scope of these guidelines.

Treatment

Acute proctitis of recent onset among persons who have recently practiced receptive anal intercourse is usually sexually acquired. Such patients should be examined by anoscopy and should be evaluated for infection with HSV, *N. gonorrhoeae*, *C. trachomatis*, and *T. pallidum*. If an anorectal exudate is found on examination, or if polymorphonuclear leukocytes are found on a Gram-stained smear of anorectal secretions, the following therapy may be prescribed pending results of additional laboratory tests.

Recommended Regimen

Ceftriaxone 125 mg IM (or another agent effective against rectal and genital gonorrhea)

PLUS

Doxycycline 100 mg orally twice a day for 7 days.

NOTE: Patients with suspected or documented herpes proctitis should be managed in the same manner as those with genital herpes (see Management of HSV Infection). If painful perianal ulcers are present or mucosal ulcers are seen on anoscopy, presumptive therapy should include a regimen for treating genital herpes.

Follow-Up

Follow-up should be based on specific etiology and severity of clinical symptoms. Reinfection may be difficult to distinguish from treatment failure.

Management of Sex Partners

Partners of patients with sexually transmitted enteric infections should be evaluated for any diseases diagnosed in the index patient.

Ectoparasitic Infections

Pediculosis Pubis

Patients who have pediculosis pubis (i.e., pubic lice) usually seek medical attention because of pruritus or because they notice lice or nits on their pubic hair. Pediculosis pubis is usually transmitted by sexual contact.

Recommended Regimens

Permethrin 1% creme rinse applied to affected areas and washed off after 10 minutes.

OR

Lindane 1% shampoo applied for 4 minutes to the affected area and then thoroughly washed off. This regimen is not recommended for pregnant or lactating women or for children aged <2 years.

OR

Pyrethrins with piperonyl butoxide applied to the affected area and washed off after 10 minutes.

Lindane toxicity, as indicated by seizure and aplastic anemia, has not been reported when treatment was limited to the recommended 4-minute period. Permethrin has less potential for toxicity than lindane.

Other Management Considerations

The recommended regimens should not be applied to the eyes. Pediculosis of the eyelashes should be treated by applying occlusive ophthalmic ointment to the eyelid margins twice a day for 10 days.

Bedding and clothing should be decontaminated (i.e., machine-washed, machine-dried using the heat cycle, or dry-cleaned) or removed from body contact for at least 72 hours. Fumigation of living areas is not necessary.

Patients with pediculosis pubis should be evaluated for other sexually transmitted diseases.

Follow-Up

Patients should be evaluated after 1 week if symptoms persist. Re-treatment may be necessary if lice are found or if eggs are observed at the hair-skin junction. Patients who do not respond to one of the recommended regimens should be re-treated with an alternative regimen.

Management of Sex Partners

Sex partners within the last month should be treated. Patients should avoid sexual contact with their sex partner(s) until patients and partners have been treated and reevaluated to rule out persistent disease.

Special Considerations

Pregnancy

Pregnant and lactating women should be treated with either permethrin or pyrethrins with piperonyl butoxide; lindane is contraindicated in pregnancy.

HIV Infection

Patients who have pediculosis pubis and also are infected with HIV should receive the same treatment regimen as those who are HIV-negative.

Scabies

The predominant symptom of scabies is pruritus. Sensitization to *Sarcoptes scabiei* must occur before pruritus begins. The first time a person is infected with *S. scabiei*, sensitization takes up to several weeks to develop. However, pruritus might occur within 24 hours after a subsequent reinfestation. Scabies in adults often is sexually acquired, although scabies in children usually is not.

Recommended Regimen

Permethrin cream (5%) applied to all areas of the body from the neck down and washed off after 8–14 hours.

Alternative Regimens

Lindane (1%) 1 oz. of lotion or 30 g of cream applied in a thin layer to all areas of the body from the neck down and thoroughly washed off after 8 hours

OR

Ivermectin 200ug/kg orally, repeated in 2 weeks.

NOTE: Lindane should not be used immediately after a bath or shower, and it should not be used by persons who have extensive dermatitis, pregnant or lactating women, or children aged <2 years.

Permethrin is effective and safe but costs more than lindane. Lindane is effective in most areas of the United States; however, lindane resistance has been reported in some areas of the world, including parts of the United States. Seizures have occurred when lindane was applied after a bath or used by patients who had extensive dermatitis. Aplastic anemia following lindane use also has been reported.

One study has demonstrated increased mortality among elderly, debilitated persons who received ivermectin, but this observation has not been confirmed in subsequent reports.

Other Management Considerations

Bedding and clothing should be decontaminated (i.e., either machine-washed, machine-dried using the hot cycle, or dry-cleaned) or removed from body contact for at least 72 hours. Fumigation of living areas is unnecessary.

Crusted Scabies

Crusted scabies (i.e., Norwegian scabies) is an aggressive infestation that usually occurs in immunodeficient, debilitated, or malnourished persons. Patients who are receiving systemic or potent topical glucocorticoids, organ transplant recipients, mentally retarded or physically incapacitated persons, HIV-infected or human T-lymphotrophic virus-1 (HTLV-1)-infected persons, and persons with various hematologic malignancies are at risk for developing crusted scabies. Crusted scabies is associated with greater transmissibility than scabies. No controlled therapeutic studies for crusted scabies have been conducted, and the appropriate treatment remains unclear. Substantial treatment failure might occur with single topical scabicide or oral ivermectin treatment. Some specialists recommend combined treatment with a topical scabicide and oral ivermectin or repeated treatments with ivermectin. Lindane should be avoided because of risks of neurotoxicity with heavy applications and denuded skin. Patient's fingernails should be closely trimmed to reduce injury from excessive scratching.

Follow-Up

Patients should be informed that the rash and pruritus of scabies may persist for up to 2 weeks after treatment. Symptoms or signs that persist for >2 weeks can be attributed to several factors. Treatment failure may be caused by resistance to medication or by faulty application of topical scabicides. Patients with crusted scabies may have poor penetration into thick scaly skin and harbor mites in these difficult-to-penetrate layers. Particular attention must be given to the fingernails of these patients. Reinfection from family members or fomites may occur in the absence of appropriate contact treatment and washing of bedding and clothing. Even when treatment is successful and reinfection is avoided, symptoms may persist or worsen as a result of allergic dermatitis. Finally, household mites might cause symptoms to persist as a result of cross-reactivity between antigens.

Some specialists recommend re-treatment after 1–2 weeks for patients who are still symptomatic; others recommend re-treatment only if live mites are observed. Patients who do not respond to the recommended treatment should be re-treated with an alternative regimen.

Management of Sex Partners and Household Contacts

Both sexual and close personal or household contacts within the preceding month should be examined and treated.

Management of Outbreaks in Communities, Nursing Homes, and Other Institutional Settings

Scabies epidemics often occur in nursing homes, hospitals, residential facilities, and communities. Control of an epidemic can only be achieved by treatment of the entire population at risk. Ivermectin can be considered in this setting, especially if treatment with topical scabicides fails. Epidemics should be managed in consultation with a specialist.

Special Considerations

Infants, Young Children, and Pregnant or Lactating Women

Infants, young children, and pregnant or lactating women should not be treated with lindane. They can be treated with permethrin.

Ivermectin is not recommended for pregnant or lactating patients. The safety of ivermectin in children who weigh <15 kg has not been determined.

HIV Infection

Patients who have uncomplicated scabies and also are infected with HIV should receive the same treatment regimens as those who are HIV-negative. HIV-infected patients and others who are immunosuppressed are at increased risk for crusted scabies. Such patients should be managed in consultation with a specialist.

Sexual Assault and STDs

Adults and Adolescents

The recommendations in this report are limited to the identification, prophylaxis, and treatment of sexually transmitted infections and conditions commonly identified in the management of such infections. The documentation of findings, collection of non-microbiologic specimens for forensic purposes, and the management of potential pregnancy or physical and psychological trauma are beyond the scope of this report. Examinations of survivors of sexual assault should be conducted so as to minimize further trauma to the survivor and should be performed by an experienced clinician. The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Mechanisms to ensure continuity of care (including timely review of the results of any tests obtained) and to monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens should be in place in any setting where survivors of sexual assault are examined. Laws in all 50 states strictly limit the evidentiary use of a survivor's prior sexual history, including evidence of previously acquired STDs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment is enforced in most states. In unanticipated, exceptional situations, STD diagnoses may later be accessed, and the survivor and clinician may opt to defer testing for this reason. However, collection of specimens at initial examination for laboratory STD diagnosis gives the survivor and clinician the option to defer empiric prophylactic antimicrobial treatment. Among sexually active adults, the identification of sexually transmitted infection after an assault is usually more important for the psychological and medical management of the patient than for legal purposes, because the infection could have been acquired before the assault.

Trichomoniasis, BV, gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who have been sexually assaulted. Because the prevalence of these infections is high among sexually active women, their presence after an assault does not necessarily signify acquisition during the assault. A post-assault examination is, however, an opportunity to identify or prevent sexually transmitted infections, regardless of whether they were acquired during an assault. Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection. In addition, post-assault evaluation can detect HBV infection, which may be prevented by postexposure administration of hepatitis B vaccine. Reproductive-aged female survivors should be evaluated for pregnancy, if appropriate.

Evaluation for Sexually Transmitted Infections

Initial Examination

An initial examination should include the following procedures.

- Cultures for *N. gonorrhoeae* and *C. trachomatis* from specimens collected from any sites of penetration or attempted penetration.
- FDA-approved nucleic acid amplification tests (as a substitute for culture). Nucleic acid amplification tests offer the advantage of increased sensitivity. If a nucleic acid amplification test is used, a positive test result should be confirmed by a second test. Confirmation tests should consist of a second FDA-licensed nucleic acid amplification test that targets a different sequence from the initial test. EIA, non-amplified probes, and direct fluorescent antibody tests are not acceptable alternatives for culture, because false-negative test results occur more often with these nonculture tests, and false-positive test results also may occur.

- Wet mount and culture of a vaginal swab specimen for *T. vaginalis* infection. If vaginal discharge, malodor, or itching is evident, the wet mount also should be examined for evidence of BV and candidiasis.
- Collection of a serum sample for immediate evaluation for HIV, hepatitis B, and syphilis (see Prophylaxis, Risk for Acquiring HIV Infection and Follow-Up Examinations 12 Weeks After Recent Assault).

Follow-Up Examinations

Although persons may have difficulty in complying with follow-up examinations several weeks following an assault, such examinations are essential because they provide an opportunity to a) detect new infections acquired during or after the assault; b) complete hepatitis B immunization, if indicated; and c) complete counseling and treatment for other STDs.

Examination for STDs should be repeated within 1–2 weeks of the assault. Because infectious agents acquired through assault may not have produced sufficient concentrations of organisms to result in positive test results at the initial examination, a culture (or cultures), a wet mount, and other tests should be repeated at the follow-up visit unless prophylactic treatment was provided. If treatment was provided, testing should be done only if the survivor reports having symptoms. If treatment was not provided, follow-up examination should be conducted within a week to ensure that results of positive tests can be discussed promptly with the survivor and that treatment is provided. Serologic tests for syphilis and HIV infection should be repeated 6, 12, and 24 weeks after the assault if initial test results were negative and these infections are likely to be present in the assailant (see Risk of Acquiring HIV Infection).

Prophylaxis

Many specialists recommend routine preventive therapy after a sexual assault because follow-up of survivors of sexual assault can be difficult and because these persons may be reassured if offered treatment or prophylaxis for possible infection. The following prophylactic regimen is suggested as preventive therapy.

- Postexposure hepatitis B vaccination, without HBIG, should adequately protect against HBV. Hepatitis B vaccine should be administered to sexual assault victims at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV may be administered.

Recommended Regimen

Ceftriaxone 125 mg IM in a single dose
PLUS
Metronidazole 2 g orally in a single dose
PLUS
Azithromycin 1 g orally in a single dose
OR
Doxycycline 100 mg orally twice a day for 7 days.

NOTE: For patients requiring alternative treatments, see the sections in this report that specifically address the appropriate agent. The efficacy of these regimens in preventing gonorrhea, trichomoniasis, BV, and *C. trachomatis* genitourinary infections after sexual assault has not been evaluated. Clinicians should counsel patients regarding the possible benefits, as well as the possible toxicity, associated with these treatment regimens; gastrointestinal side effects can occur with this combination. Providers may also consider anti-emetic medications if prophylaxis is administered, particularly if emergency contraception is also provided.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding the following:

- symptoms of STDs and the need for immediate examination if symptoms occur and
- abstinence from sexual intercourse until STD prophylactic treatment is completed.

Risk for Acquiring HIV Infection

Although HIV-antibody seroconversion has been reported among persons whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through a single episode of sexual assault is likely low. The overall probability of HIV transmission during a single act of intercourse from a person known to be HIV-infected, however, depends on many factors, and in specific circumstances could be high. These factors may include the type of sexual intercourse (i.e., oral, vaginal, or anal); presence of oral, vaginal, or anal trauma (including bleeding); site of exposure to ejaculate; viral load in ejaculate; and presence of an STD or genital lesions in assailant or survivor. Children may be at higher risk for transmission, because child sexual abuse is often associated with multiple episodes of assault and may result in mucosal trauma (see Sexual Assault or Abuse of Children).

In certain circumstances, the potential of HIV transmission has been reduced by postexposure therapy for HIV with antiretroviral agents. Postexposure therapy with zidovudine has been associated with a reduced risk for HIV infection in a

study of health-care workers who had percutaneous exposures to HIV-infected blood. On the basis of these results and the biologic plausibility of the effectiveness of antiretroviral agents in preventing infection, postexposure therapy has been recommended for health-care workers who have occupational exposures to HIV. The degree to which these findings can be extrapolated to other HIV-exposure situations, including sexual assault, is unknown. Although a definitive recommendation cannot be made regarding postexposure antiretroviral therapy after sexual exposure to HIV, such therapy should be considered in cases in which the risk for HIV exposure during the assault is likely high.

Health-care providers who consider offering postexposure therapy should take into account the likelihood of exposure to HIV, the potential benefits and risks of such therapy, and the interval between the exposure and initiation of therapy. Timely determination of the HIV-infection status of the assailant is not possible in many sexual assaults. Therefore, the health-care provider should assess the local epidemiology of HIV/AIDS, the nature of the assault, and any available information about HIV-risk behaviors exhibited by the assailant(s) (e.g., high-risk sexual practices and injection-drug or crack cocaine use). When an assailant's HIV status is unknown, factors that should be considered in determining whether an increased risk of HIV transmission exists include a) whether oral, vaginal, or anal penetration occurred; b) whether ejaculation occurred on mucous membranes; c) whether multiple assailants were involved; d) whether mucosal lesions are present in assailant or survivor; and e) other characteristics of the assault, survivor, or assailant. If antiretroviral postexposure prophylaxis is offered, the following information should be discussed with the patient: a) the unknown efficacy and known toxicities of antiretrovirals; b) the close follow-up that is necessary; c) the importance of strict compliance with the recommended therapy; and d) the necessity of immediate initiation of treatment for maximal likelihood of effectiveness (as soon as possible after, and up to 72 hours following, the most recent assault). Providers should emphasize that although data are limited, postexposure antiretroviral therapy appears to be well tolerated in both adults and children, and severe adverse effects are rare. Personnel likely to examine survivors of sexual assault should consult with federal or state health departments or other professionals knowledgeable in STDs to develop algorithms and protocols for the determination of risk for exposure to HIV and management in their community. Clinical management of the patient should be implemented according to the following guidelines (*107,108*). If postexposure HIV prophylaxis is being considered, consultation with an HIV specialist is recommended.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors within 72 hours of Sexual Assault §§§

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in HIV treatment if postexposure prophylaxis is considered.
- If the survivor appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and unknown efficacy.
- If the survivor chooses to receive antiretroviral postexposure prophylaxis *(107)*, provide enough medication to last until the next return visit; reevaluate survivor 3–7 days after initial assessment and assess tolerance of medications.
- Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Sexual Assault or Abuse of Children

Recommendations in this report are limited to the identification and treatment of STDs. Management of the psychosocial aspects of the sexual assault or abuse of children is beyond the scope of these recommendations.

The identification of sexually transmissible agents in children beyond the neonatal period suggests sexual abuse. The significance of the identification of a sexually transmitted agent in such children as evidence of possible child sexual abuse varies by pathogen. Postnatally acquired gonorrhea; syphilis; and non-transfusion, non-perinatally acquired HIV are usually diagnostic of sexual abuse. Sexual abuse should be suspected in the presence of genital herpes. The investigation of sexual abuse among children who possibly have a sexually transmitted infection should be conducted in compliance with recommendations by clinicians who have experience and training in all elements of the evaluation of child abuse, neglect, and assault (*109–111*). The social significance of each sexually transmitted infection and the recommended action regarding reporting of suspected child sexual abuse varies by STD (Table 5). In all cases in which a sexually transmitted infection has been diagnosed in a child, efforts should be made to detect evidence of sexual abuse, including conducting diagnostic testing for other commonly occurring sexually transmitted infections (*109,110*).

§§§ Assistance with postexposure prophylaxis decisions can be obtained by calling the National HIV Telephone Consultation Service (tel: 800-933-3413).

TABLE 5. Implications of commonly encountered sexually transmitted (ST) or sexually associated (SA) infections for diagnosis and reporting of sexual abuse among infants and pre-pubertal children

ST/SA Confirmed	Evidence for sexual abuse	Suggested action
Gonorrhea*	Diagnostic	Report†
Syphilis*	Diagnostic	Report†
Human Immunodeficiency Virus§	Diagnostic	Report†
*Chlamydia trachomatis**	Diagnostic	Report†
Trichomonas vaginalis	Highly suspicious	Report†
Condylomata acuminata (anogenital warts)*	Suspicious	Report†
Genital herpes*	Suspicious	Report†¶
Bacterial vaginosis	Inconclusive	Medical follow-up

Source: Adapted from American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1999;103:186–91. Published correction *Pediatrics* 1999;103:149.

* If not likely to be perinatally acquired.
† Reports should be made to the agency in the community mandated to receive reports of suspected child abuse or neglect.
§ If not likely to be acquired perinatally or through transfusion.
¶ Unless there is a clear history of autoinoculation.

The general rule that sexually transmissible infections beyond the neonatal period are evidence of sexual abuse has exceptions. For example, rectal or genital infection with *C. trachomatis* among young children may be the result of perinatally acquired infection and has, in some cases, persisted for as long as 2–3 years. Genital warts have been diagnosed in children who have been sexually abused, but also in children who have no other evidence of sexual abuse. BV has been diagnosed in children who have been abused, but its presence alone does not prove sexual abuse. Most HBV infections in children result from household exposure to persons who have chronic HBV infection.

The possibility of sexual abuse should be strongly considered if no conclusive explanation for non-sexual transmission of a sexually transmitted infection can be identified. When the only evidence of sexual abuse is the isolation of an organism or the detection of antibodies to a sexually transmissible agent, findings should be confirmed and the implications considered carefully.

Evaluation for Sexually Transmitted Infections

Examinations of children for sexual assault or abuse should be conducted so as to minimize pain and trauma to the child. Collection of vaginal specimens in prepubertal children can be very uncomfortable and should be performed by an experienced clinician to avoid psychological and physical trauma to the child. The decision to obtain genital or other specimens from a child to conduct an STD evaluation must be made on an individual basis. The following situations involve a high risk for STDs and constitute a strong indication for testing.

- The child has or has had symptoms or signs of an STD or of an infection that can be sexually transmitted, even in the absence of suspicion of sexual abuse. Among the signs that are associated with a confirmed STD diagnosis are vaginal discharge or pain; genital itching or odor; urinary symptoms; and genital ulcers or lesions (*112*).
- A suspected assailant is known to have an STD or to be at high risk for STDs (e.g., has multiple sex partners or a history of STDs).
- A sibling or another child or adult in the household or child's immediate environment has an STD (*113*).
- The patient or parent requests testing.
- The prevalence of STDs in the community is high.
- Evidence of genital, oral, or anal penetration or ejaculation is present.

If a child has symptoms, signs, or evidence of an infection that might be sexually transmitted, the child should be tested for other common STDs before the initiation of any treatment that could interfere with the diagnosis of those other STDs. Because of the legal and psychosocial consequences of a false-positive diagnosis, only tests with high specificities should be used. The potential social benefit to the child of a reliable diagnosis of an STD justifies deferring presumptive treatment until specimens for highly specific tests are obtained by providers with experience in the evaluation of sexually abused and assaulted children.

The scheduling of examination should depend on the history of assault or abuse. If the initial exposure was recent, the infectious agents acquired through the exposure may not have produced sufficient concentrations of organisms to result in positive test results. A follow-up visit approximately 2 weeks after the most recent sexual exposure may include a repeat physical examination and collection of additional specimens. To allow sufficient time for antibodies to develop, another follow-up visit approximately 12 weeks after most recent sexual exposure may be necessary to collect sera. A single examination may be sufficient if the child was abused for an extended time period and if the last suspected episode of abuse occurred well before the child received medical evaluation.

The following recommendations for scheduling examinations serve as a general guide. The exact timing and nature of follow-up examinations should be determined on an individual basis and should be performed so as to minimize the possibility for psychological trauma and social stigma. Compliance with follow-up appointments might be improved when law enforcement personnel or child protective services are involved.

Initial and 2-Week Follow-Up Examinations

During the initial examination and 2-week follow-up examination (if indicated), the following should be performed.

- Visual inspection of the genital, perianal, and oral areas for genital discharge, odor, bleeding, irritation, warts, and ulcerative lesions. The clinical manifestations of some STDs are different in children than in adults. For example, typical vesicular lesions may not be present in the presence of herpes simplex virus infection. Because this infection is indicative of probable sexual abuse, specimens should be obtained from all vesicular or ulcerative genital or perianal lesions compatible with genital herpes and then sent for viral culture.
- Specimen collection for culture for *N. gonorrhoeae* from the pharynx and anus in both boys and girls, the vagina in girls, and the urethra in boys. Cervical specimens are not recommended for pre-pubertal girls. For boys with a urethral discharge, a meatal specimen discharge is an adequate substitute for an intraurethral swab specimen. Only standard culture systems for the isolation of *N. gonorrhoeae* should be used. All presumptive isolates of *N. gonorrhoeae* should be confirmed by at least two tests that involve different principles (i.e., biochemical, enzyme substrate, serologic, or DNA probe methods). Isolates and specimens should be retained or preserved in case additional or repeated testing is needed. Gram stains are inadequate to evaluate pre-pubertal children for gonorrhea and should not be used to diagnose or exclude gonorrhea.
- Cultures for *C. trachomatis* from specimens collected from the anus in both boys and girls and from the vagina in girls. Some data suggest that the likelihood of recovering *C. trachomatis* from the urethra of prepubertal boys is too low to justify the trauma involved in obtaining an intraurethral specimen. However, a meatal specimen should be obtained if urethral discharge is present. Pharyngeal specimens for *C. trachomatis* are not recommended for children of either sex because the yield is low, perinatally acquired infection may persist beyond infancy, and culture systems in some laboratories do not distinguish between *C. trachomatis* and *C. pneumoniae*. Only standard culture systems for the isolation of *C. trachomatis* should be used. The isolation of *C. trachomatis* should be confirmed by microscopic identification of inclusions by staining with fluorescein-conjugated monoclonal antibody specific for *C. trachomatis;* EIAs are not acceptable confirmatory methods. Isolates should be preserved. Nonculture tests for chlamydia (e.g., non-amplified probes, EIAs, and DFA), are not sufficiently specific for use in circumstances involving possible child abuse or assault. Data are insufficient to adequately assess the utility of nucleic acid amplification tests in the evaluation of children who might have been sexually abused, but these tests may be an alternative only if confirmation is available and culture systems for *C. trachomatis* are unavailable. Confirmation tests should consist of a second FDA-approved nucleic acid amplification test that targets a different sequence from the initial test.
- Culture and wet mount of a vaginal swab specimen for *T. vaginalis* infection and BV.
- Collection of a serum sample to be evaluated immediately, preserved for subsequent analysis, and used as a baseline for comparison with follow-up serologic tests. Sera should be tested immediately for antibodies to sexually transmitted agents. Agents for which suitable tests are available include *T. pallidum*, HIV, and HbsAg. Decisions regarding which agents to use for serologic tests should be made on a case-by-case basis (see Examination 12 Weeks after Assault).

HIV infection has been reported in children whose only known risk factor was sexual abuse. Serologic testing for HIV infection should be considered for abused children. The decision to test for HIV infection should be made on a case-by-case basis, depending on the likelihood of infection among assailant(s). Data are insufficient concerning the efficacy and safety of postexposure prophylaxis among both children and adults. However, antiretroviral treatment is well tolerated by infants and children with and without HIV infection; in addition, children who receive such treatment have a minimal risk for serious adverse reactions because of the short period of time recommended for prophylaxis *(30,114)*. In those cases in which a child presents to a health-care provider shortly after a sexual exposure (i.e., within 72 hours), the assailant(s) are likely to be at risk for HIV infection, and likelihood of compliance with treatment regimens is high, the potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions. If antiretroviral postexposure prophylaxis is being considered, a professional specializing in HIV-infected children should be consulted.

Recommendations for Postexposure Assessment of Children within 72 Hours of Sexual Assault

- Review HIV/AIDS local epidemiology and assess risk for HIV infection in the assailant.
- Evaluate circumstances of assault that may affect risk for HIV transmission.
- Consult with a specialist in treating HIV-infected children if postexposure prophylaxis is considered.
- If the child appears to be at risk for HIV transmission from the assault, discuss postexposure prophylaxis with the caregiver(s), including its toxicity and its unknown efficacy.

- If caregivers choose for the child to receive antiretroviral postexposure prophylaxis (*29,114*), provide enough medication until the return visit at 3–7 days after initial assessment to reevaluate child and to assess tolerance of medication; dosages should not exceed those for adults.
- Perform HIV antibody test at original assessment, 6 weeks, 3 months, and 6 months.

Examination 12 Weeks After Assault

In circumstances in which transmission of syphilis, HIV, or hepatitis B is a concern but baseline tests are negative, an examination approximately 12 weeks after the last suspected sexual exposure is recommended to allow time for antibodies to infectious agents to develop. The prevalence of these infections differs substantially by community. In addition, results of HBsAg testing must be interpreted carefully, because HBV can be transmitted non-sexually. Decisions regarding which tests should be performed must be made on an individual basis.

Presumptive Treatment

The risk of a child acquiring an STD as a result of sexual abuse or assault has not been determined. Presumptive treatment for children who have been sexually assaulted or abused is not recommended because a) the prevalence of most STDs is low following abuse/assault, b) pre-pubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and c) regular follow-up of children usually can be ensured. However, some children or their parent(s) or guardian(s) may be concerned about the possibility of infection with an STD, even if the risk is perceived to be low by the health-care provider. Such concerns may be an appropriate indication for presumptive treatment in some settings and may be considered after all specimens for diagnostic tests relevant to the investigation have been collected.

Reporting

Every state and U.S. territory has laws that require the reporting of child abuse. Although the exact requirements differ by state, if a health-care provider has reasonable cause to suspect child abuse, a report must be made. Health-care providers should contact their state or local child-protection service agency about child-abuse reporting requirements in their areas.

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Abbreviations Used in This Publication

ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ACS	American Cancer Society
AIDS	Acquired immunodeficiency syndrome
ALT	Alanine aminotransferase
anti-HBc	Antibody to the hepatitis B core antigen
ASCUS	Atypical squamous cells of undetermined significance
BCA	Bichloroacetic acid
BV	Bacterial vaginosis
CBC	Complete blood count
CDC	Centers for Disease Control and Prevention
CI	Confidence interval
CIN	Cervical intraepithelial neoplasia
CLD	Chronic liver disease
CMV	Cytomegalovirus
CNS	Central nervous system
CSF	Cerebrospinal fluid
d4T	Stavudine
ddC	Dideoxycytodine
ddI	Didanosine
DFA	Direct fluorescent antibody
DGI	Disseminated gonococcal infection
dL	Deciliter
DNA	Deoxyribonucleic acid
EIA	Enzyme immunoassay
ELISA	Enzyme-linked immunosorbent assay
FDA	Food and Drug Administration
FTA-ABS	Fluorescent treponemal antibody absorbed
gG	glycoprotein G
GISP	Gonococcal Isolate Surveillance Project
HAV	Hepatitis A virus
HBIG	Hepatitis B immune globulin
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus

HSV	Herpes simplex virus
HTLV-1	Human T-cell lymphotrophic virus type I
IDV	Indinavir
IDU	Injection drug user
IFA	Immunofluorescence assay
IgE	Immunoglobulin E
Ig	Immune globulin
IgG	Immunoglobulin G
IHPS	Infantile hypertrophic pyloric stenosis
IM	Intramuscularly
IV	Intravenous or intravenously
kg	Kilogram
KOH	Potassium hydroxide
LGV	Lymphogranuloma venereum
MAC	*Mycobacterium avium* complex
mg	Milligram
MIC	Minimum inhibitory concentration
MMWR	*Morbidity and Mortality Weekly Report*
MPC	Mucopurulent cervicitis
MRL	Microbiology Reference Library
MSM	Men who have sex with men
N-9	Nonoxynol-9
NAAT	Nucleic acid amplification test
NGU	Nongonococcal urethritis
OTC	Over-the-counter
Pap	Papanicolaou
PCP	*Pneumocystis carinii* pneumonia
PCR	Polymerase chain reaction
PEP	Postexposure prophylaxis
PID	Pelvic inflammatory disease
PPD	Purified protein derivative
PPV	Positive predictive value
QRNG	Quinolone resistant *Neisseria gonorrhoeae*
RIBA	Recombinant immunoblot assay
RNA	Ribonucleic acid
RPR	Rapid plasma reagin
RT-PCR	Reverse transcriptase polymerase chain reaction
RVVC	Recurrent vulvovaginal candidiasis
SAQ	Saquinavir
SIL	Squamous intraepithelial lesion
STD	Sexually transmitted disease
TB	Tuberculosis
TCA	Trichloroacetic acid
TE	Toxoplasmic encephalitis
TMP-SMX	Trimethoprim-sulfamethoxazole
TP-PA	Treponema pallidum particle agglutation
TST	Tuberculin skin test
VDRL	Venereal Disease Research Laboratory
VFC	Vaccines for children
VVC	Vulvovaginal candidiasis
WB	Western blot
WBC	White blood count
ZDV	Zidovudine
3TC	Lamivudine

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- Document 17: Photograph and Biographical Sketch of Amanda Berry Smith

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Why Did African-American Women Join the Woman's Christian Temperance Union between 1880 to 1900?

Abstract

The Woman's Christian Temperance Union was one of the first national women's reform organizations that welcomed the reform efforts of middle-class African-American women. This project explores the achievements of African-American women through the Union's Colored Department between 1880 and 1900 and the tensions that emerged in an era which saw declining opportunities for interracial work.

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What Was the Appeal of Moral Reform to Antebellum Northern Women, 1835-1841?

Abstract

During the 1830s and 1840s, middle-class women in New England and the Middle Atlantic states organized Female Moral Reform societies in order to attack the sexual double standard. The documents in this project, drawn largely from moral reform newspapers published in New York and Boston, examine the appeal and tactics of the movement, arguably the first social movement in the United States to be led by and consist largely of women.

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