TESTIMONY OF DAVID S. FISHBACK BEFORE THE MONTGOMERY COUNTY BOARD OF EDUCATION JULY 27, 2005

Last month, the PFOX/CRC lawyer asked you to develop a health curriculum that's "not offensive." What did PFOX/CRC find offensive in the pilot curriculum that their lawsuit derailed?

Was it the use of definitions from the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association?

Was it the factual statements:

That "all major professional mental health organizations affirm that homosexuality is not a mental disorder"?

That "most experts in the field have concluded that sexual orientation is not a choice"?

That "different religions take different stands on sexual behaviors and there are even different views among people of the same religion"?

That "having homosexual parents/guardians does not predispose you to being homosexual"?

That there are families in our community headed by same-sex couples?

I have just described nearly everything on sexual orientation contained in the derailed curriculum. PFOX/CRC apparently find this offensive, as they find offensive any omission of their perspective on so-called "reparative therapy." At your last meeting, PFOX president Richard Cohen alluded to reparative therapy, while misrepresenting much of what PFOX and like-minded James Dobson-connected groups do. Perhaps the misrepresentations are not surprising, for the American Counseling Association has expelled Mr. Cohen for life for unethical conduct.

All mainstream health care organizations reject the PFOX/CRC approach. The American Medical Association specifically states that it "opposes the use of 'reparative' or 'conversion' therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation" (AMA Policy Number H-160.991, attached).

MCPS has a choice: It may choose not to offend PFOX/CRC OR it may choose to follow the lead and wisdom of the mainstream health care professionals and end the silence on sexual orientation which has caused so much harm in the past. Indeed, failure to do the latter would be offensive to the vast majority of MCPS stakeholders.

I have confidence that you will choose wisely.

For your convenience, I have attached pertinent documents from the AMA and other mainstream health groups.

Attachments:

Documents of the
- American Medical Association
- American Academy of Pediatrics
- American Psychiatric Association
- American Psychological Association
- American Academy of Child and Adolescent Psychiatry

Letter from the American Counseling Association, expelling Richard Cohen.

DOCUMENTS FROM MAINSTREAM MEDICAL AND MENTAL HEALTH PROFESSIONAL ASSOCIATIONS

July 2005

H-160.991 Health Care Needs of the Homosexual Population

Our AMA: (1) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (2) is committed to taking a leadership role in: (a) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (b) educating physicians to recognize the physical and psychological needs of their homosexual patients; (c) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (d) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (e) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (3) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00)

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AMERICAN ACADEMY OF PEDIATRICS

CLINICAL REPORT
Guidance for the Clinician in Rendering Pediatric Care

Barbara L. Frankowski, MD, MPH; and the Committee on Adolescence

Sexual Orientation and Adolescents

ABSTRACT. **The American Academy of Pediatrics issued its first statement on homosexuality and adolescents in 1983, with a revision in 1993. This report reflects the growing understanding of youth of differing sexual orientations. Young people are recognizing their sexual orientation earlier than in the past, making this a topic of importance to pediatricians. Pediatricians should be aware that some youths in their care may have concerns about their sexual orientation or that of siblings, friends, parents, relatives, or others. Health care professionals should provide factual, current, nonjudgmental information in a confidential manner. All youths, including those who know or wonder whether they are not heterosexual, may seek information from physicians about sexual orientation, sexually transmitted diseases, substance abuse, or various psychosocial difficulties. The pediatrician should be attentive to various potential psychosocial difficulties, offer counseling or refer for counseling when necessary and ensure that every sexually active youth receives a thorough medical history, physical examination, immunizations, appropriate laboratory tests, and counseling about sexually transmitted diseases (including human immunodeficiency virus infection) and appropriate treatment if necessary.**

Not all pediatricians may feel able to provide the type of care described in this report. Any pediatrician who is unable to care for and counsel nonheterosexual youth should refer these patients to an appropriate colleague. *Pediatrics* **2004;113:1827–1832;** ***sexual orientation, adolescents, homosexuality, gay, lesbian, bisexual.***

ABBREVIATIONS. STD, sexually transmitted disease; HIV, human immunodeficiency virus; AAP, American Academy of Pediatrics; AIDS, acquired immunodeficiency syndrome.

INTRODUCTION

Pediatricians are being asked with increasing frequency to address questions about sexual behavior and sexual orientation. It is important that pediatricians be able to discuss the range of sexual orientation with all adolescents and be competent in dealing with the needs of patients who are gay, lesbian, bisexual, or transgendered or who may not identify themselves as such but who are experiencing confusion with regard to their sexual orientation. Young people whose sexual orientation is not heterosexual can have risks to their physical, emotional, and social health, primarily because of societal stigma, which can result in isolation.[1,2] Because self-awareness of sexual orientation commonly occurs during adolescence, the pediatrician should be available to youth who are struggling with sexual orientation issues and support a healthy passage through the special challenges of the adolescent years. Pediatricians may be called on to help parents, siblings, and extended families of nonheterosexual youth. Also, nonheterosexual youth and adults are part of peer groups with whom all pediatric patients and their parents spend time in the neighborhood, at school, or at work. Thus, pediatricians may be called on to help promote better understanding of issues involving nonheterosexual youth.

Gay, lesbian, and bisexual people in the United States have unique health risks. The US Department of Health and Human Services has identified 29 *Healthy People 2010* objectives in which disparities exist between homosexual or bisexual persons and heterosexual persons. These focus areas include access to care, educational and community-based programs, family planning, immunization and infectious disease, sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection, injury and violence prevention, mental health and mental disorders, substance abuse, and tobacco use.[3]

DEFINITIONS

Sexual orientation[4,5] refers to an individual's pattern of physical and emotional arousal toward other persons. Heterosexual individuals are attracted to persons of the opposite sex, homosexual individuals are attracted to persons of the same sex, and bisexual individuals are attracted to persons of both sexes. Homosexual males are often referred to as "gay"; homosexual females are often referred to as "lesbian." In contrast, gender identity is the knowledge of oneself as being male or female, and gender role is the outward expression of maleness or femaleness. Gender identity and gender role usually conform to anatomic sex in both heterosexual and homosexual individuals. Exceptions to this are transgendered individuals and transvestites. Transgendered individuals feel themselves to be of a gender different from their biological sex; their gender identity does not match their anatomic or chromosomal sex. Transvestites are individuals who dress in the clothing of the opposite gender and derive pleasure from such ac-

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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tions; their gender role does not match societal norms. Transgendered individuals and transvestites can be heterosexual, homosexual, or bisexual.

Sexual orientation is not synonymous with sexual activity or sexual behavior (the way one chooses to express one's sexual feelings). Certain sexual behaviors can put individuals of any sexual orientation at risk of pregnancy (penile-vaginal sexual intercourse) and/or certain diseases (penile-vaginal, oral, and anal sexual intercourse). Especially during adolescence, individuals may participate in a variety of sexual behaviors. Many homosexual adults report having relationships and sexual activity with persons of the opposite sex as adolescents,[6,7] and many adults who identify themselves as heterosexual report sexual activity with persons of the same sex during adolescence.[8–10] Also, many youth label themselves as gay, lesbian, or bisexual years after labeling their attractions as such.[11] In addition, adolescents may also self-identify as nonheterosexual without ever being sexually active. Pediatricians need to understand that they should inquire about sexual attraction or orientation even when youth do not report being gay or lesbian.

ETIOLOGY AND PREVALENCE

Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available.[4] Societal attitudes toward homosexuality have had a decisive effect on the extent to which individuals have hidden or made known their sexual orientation.

Human sexual orientation most likely exists as a continuum from solely heterosexual to solely homosexual. In 1973, the American Psychiatric Association reclassified homosexuality as a sexual orientation or expression and not a mental disorder.[12] The mechanisms for the development of a particular sexual orientation remain unclear, but the current literature and most scholars in the field state that one's sexual orientation is not a choice; that is, individuals do not choose to be homosexual or heterosexual.[8,11]

A variety of theories about the influences on sexual orientation have been proposed.[5] Sexual orientation probably is not determined by any one factor but by a combination of genetic, hormonal, and environmental influences.[2] In recent decades, biologically based theories have been favored by experts. The high concordance of homosexuality among monozygotic twins and the clustering of homosexuality in family pedigrees support biological models. There is some evidence that prenatal androgen exposure influences development of sexual orientation, but postnatal sex steroid concentrations do not vary with sexual orientation. The reported association in males between homosexual orientation and loci on the X chromosome remains to be replicated. Some research has shown neuroanatomic differences between homosexual and heterosexual persons in sexually dimorphic regions of the brain.[5] Although there continues to be controversy and uncertainty as to the genesis of the variety of human sexual orientations, there is no scientific evidence that abnormal parenting, sexual abuse, or other adverse life events influence sexual orientation.[4,5] Current knowledge suggests that sexual orientation is usually established during early childhood.[1,2,4,5]

The estimated proportion of Americans who are homosexual is imprecise at best, because surveys are hampered by the stigmatization and the climate of fear that still surround homosexuality. Past studies asked more often about sexual behavior and not sexual orientation. Kinsey et al,[9,13] from their studies in the 1930s and 1940s, reported that 37% of adult men and 13% of adult women had at least 1 sexual experience resulting in orgasm with a person of the same sex and that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies. A more recent review of various US studies estimated that 2% of men are exclusively homosexual and 3% are bisexual.[14] Other current studies conclude that somewhere between 3% and 10% of the adult population is gay or lesbian, and perhaps a larger percentage is bisexual.[4,5] Sorenson[15] surveyed a group of 16- to 19-year-olds and reported that 6% of females and 17% of males had at least 1 sexual experience with a person of the same sex. Remafedi et al,[10] in a large, population-based study of junior and senior high school students performed in the late 1980s that measured sexual fantasy, emotional attraction, and sexual behavior, found that more than 25% of 12-year-old students felt uncertain about their sexual orientation. This uncertainty decreased with the passage of time and increasing sexual experience to only 5% of 18-year-old students. Only 1.1% of students reported themselves as predominantly homosexual or bisexual. However, 4.5% reported primary sexual attractions to persons of the same sex, which better reflects actual sexual orientation. The Garofalo et al study,[16] based on the 1995 Massachusetts Youth Risk Behavior Survey, found that 2.5% of youth self-identified as gay, lesbian, or bisexual.

These data illustrate the complexity of labeling sexual orientation in adolescents. Health care professionals should be aware that a large number of adolescents have questions about their sexual feelings; some are attracted to and may have sexual relations with people of the same sex, and a small number may know themselves to be gay or lesbian.

SPECIAL NEEDS OF NONHETEROSEXUAL AND QUESTIONING YOUTH

The overall goal in caring for youth who are or think they might be gay, lesbian, or bisexual is the same as for all youth: to promote normal adolescent development, social and emotional well-being, and physical health. If their environment is critical of their emerging sexual orientation, these adolescents may experience profound isolation and fear of discovery, which interferes with achieving developmental tasks of adolescence related to self-esteem, identity, and intimacy.[17,18] Nonheterosexual youth often are subjected to harassment and violence; 45% of gay men and 20% of lesbians surveyed were victims of verbal and physical assaults in secondary school specifically because of their sexual orientation.[1,19]

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Nonheterosexual youth are at higher risk of dropping out of school, being kicked out of their homes, and turning to life on the streets for survival. Some of these youth engage in substance use, and they are more likely than heterosexual peers to start using tobacco, alcohol, and illegal drugs at an earlier age.[20] Nonheterosexual youth are more likely to have had sexual intercourse, to have had more partners, and to have experienced sexual intercourse against their will,[20] putting them at increased risk of STDs including HIV infection. In a recent study of HIV seroprevalence, 7% of 3492 15- to 22-year-old males who have sex with males living in 7 US cities were HIV-seropositive. Among adolescent males who have sex with males, HIV seroprevalence rates in descending order were highest among black adolescents, then "mixed race or other" adolescents, and then Hispanic adolescents and were lowest among Asian and white adolescents.[21] Women having sex with women have the lowest risk of any STD, but lesbian adolescents remain at significant risk because they are likely to have had sexual intercourse with males. Youth in high school who identify themselves as gay, lesbian, or bisexual; engage in sexual activity with persons of the same sex; or report same-sex romantic attractions or relationships are more likely to attempt suicide, be victimized, and abuse substances.[20,22] Although only representing a portion of youth who someday will self-identify as gay, lesbian, or bisexual, school-based studies have found that these adolescents, compared with heterosexual peers, are 2 to 7 times more likely to attempt suicide,[16,19,23,24] are 2 to 4 times more likely to be threatened with a weapon at school,[16,23] and are more likely to engage in frequent and heavy use of alcohol, marijuana, and cocaine. It is important to note that these psychosocial problems and suicide attempts in nonheterosexual youth are neither universal nor attributable to homosexuality per se, but they are significantly associated with stigmatization of gender nonconformity, stress, violence, lack of support, dropping out of school, family problems, acquaintances' suicide attempts, homelessness, and substance abuse.[2,25] In addition to suicidality, young gay and bisexual men might also suffer body image dissatisfaction and disordered eating behaviors for some of the same reasons.[26]

Nonheterosexual youth are represented within all populations of adolescents, all social classes, and all racial and ethnic groups. Ethnic minority youth who are nonheterosexual are required to manage more than one stigmatized identity, which increases their level of vulnerability and stress.[27] They retain their minority status when they seek help in the predominately white gay and lesbian support communities. In addition, sexual minority youth are represented among handicapped adolescents, homeless adolescents, and incarcerated youth.[1]

Most nonheterosexual youths are "invisible" and will pass through pediatricians' offices without raising the issue of sexual orientation on their own. Therefore, health care professionals should raise issues of sexual orientation and sexual behavior with all adolescent patients or refer them to a colleague who can. Such discussions normalize the notion that there is a range of sexual orientation. The portrayal of openly gay or lesbian characters in media is starting to change how adolescents view these differences. Even adolescents who are quite sure of their own heterosexuality are likely to have friends, relatives, teachers, etc whom they know or suspect to be gay or lesbian or who are struggling with questions about their sexual orientation. Rather than asking patients whether they have a "boyfriend" or "girlfriend," pediatricians could ask, "Have you ever had a romantic relationship with a boy or a girl?" or "When you think of people to whom you are sexually attracted, are they men, women, both, neither, or are you not sure yet?" By doing so, pediatricians open the door to additional communication and start to break down stereotypes and stigmatization. It implies that any of the options is possible and that an adolescent may not be sure of his or her sexual orientation. If these issues are addressed, specifically targeted medical screening, medical treatment, and anticipatory guidance can be provided to adolescents who need it. Pediatricians can have an important positive effect on young people and their families by addressing sexual orientation and sexual behavior on several levels: office and hospital policies, clinical care, and community advocacy.[2]

OFFICE PRACTICE: ENSURE A SAFE AND SUPPORTIVE ENVIRONMENT

A pediatric encounter may give adolescents a rare opportunity to discuss their concerns about their sexual orientation and/or activities. Adolescents' level of comfort in the pediatric office sets the tone for their other health care interactions. The way sexuality and other important personal issues are discussed also sets an example for all adolescents and their parents. In the office, pediatricians are encouraged to[28]:

1. Assure the patient that his or her confidentiality is protected.[29]
2. Implement policies against insensitive or inappropriate jokes and remarks by office staff.
3. Be sure that information forms use gender-neutral, nonjudgmental language.
4. Consider displaying posters, brochures, and information on bulletin boards that demonstrate support of issues important to nonheterosexual youth and their families (eg, the American Academy of Pediatrics [AAP] brochure "Gay, Lesbian, and Bisexual Teens: Facts for Teens and their Parents").
5. Provide information about support groups and other resources to nonheterosexual youth and their friends and families if requested.

COMPREHENSIVE HEALTH CARE FOR ALL ADOLESCENTS

Pediatricians are not responsible for labeling or even identifying nonheterosexual youth. Instead, the pediatrician should create a clinical environment in which clear messages are given that sensitive personal issues including sexual orientation can be discussed whenever the adolescent feels ready to do so. A major obstacle to effective medical care is adoles-

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cents' misunderstanding of their right to confidential care.[30] The pediatrician should be ready to raise and discuss issues of sexual orientation with all adolescents, particularly those in distress or engaged in high-risk behaviors. The pediatrician should be able to explore the adolescent's understanding and concerns about sexual orientation, dispel any misconceptions, provide appropriate medical care and anticipatory guidance, and connect the adolescent to appropriate supportive community resources. Pediatricians are encouraged to[29,31]:

1. Be aware of the special issues surrounding the development of sexual orientation.[29]
2. Assure the patient that his or her confidentiality is protected.[29]
3. Discuss emerging sexuality with all adolescents.[32]
   - Be knowledgeable that many heterosexual youth also may have sexual experiences with people of their own sex. Labeling as homosexual an adolescent who has had sexual experiences with persons of the same sex or is questioning his or her sexual orientation could be premature, inappropriate, and counterproductive.
   - Use gender-neutral language in discussing sexuality; use the word "partner" rather than "boyfriend" or "girlfriend," and talk about "protection" rather than just "birth control."
   - Give evidence of support and acceptance to adolescents questioning their sexual orientation.
   - Provide information and resources regarding gay, lesbian, and bisexual issues to all interested adolescents.
   - Ask all adolescents about risky behaviors, depression, and suicidal thoughts.
   - Encourage abstinence, discourage multiple partners, and provide "safer sex" guidelines to all adolescents.[33] Discuss the risks associated with anal intercourse for those who choose to engage in this behavior, and teach them ways to decrease risk.
   - Counsel all adolescents about the link between substance use (alcohol, marijuana, and other drugs) and unsafe sexual intercourse.
   - Ask all adolescents about personal experience with violence including sexual or intimate-partner violence.

   Provide additional screening and education as indicated for each adolescent's sexual activity:
   - STD testing from appropriate sites[34]
   - HIV testing with appropriate support and counseling[35]
   - Pregnancy testing and counseling[36,37]
   - Papanicolaou testing
   - Hepatitis B and, when appropriate, hepatitis A immunization
4. Ensure that colleagues to whom adolescents are referred or with whom you consult are respectful of the range of adolescents' sexual orientation.

SPECIAL CONSIDERATIONS FOR NONHETEROSEXUAL YOUTH

For adolescents who self-identify as gay, lesbian, or bisexual, pediatricians should be particularly aware of several points:

1. Be prepared to refer adolescents' care if you have personal barriers to providing such care. Many individuals have strong negative attitudes about homosexuality or may simply feel uncomfortable with the subject. Even discomfort expressed through body language can send a very damaging message to nonheterosexual youth. It is an ethical and professional obligation to make an appropriate referral in these situations for the good of the child or adolescent.
2. Assure the patient that his or her confidentiality is protected.[29] Discuss with adolescents and, if appropriate, their parents whether they wish to have their sexual orientation recorded in office and hospital charts. Many nonheterosexual adults prefer to have this information recorded so that health care professionals will not assume heterosexuality.
3. Help the adolescent think through his or her feelings carefully; strong same-sex feelings and even sexual experiences can occur at this age and do not define sexual orientation.
4. Carefully identify all risky behaviors (sexual behaviors; use of tobacco, alcohol, and drugs; etc) and offer advice and treatment if indicated.
5. Ask about mental health concerns and evaluate or refer patients with identified problems.
6. Offer support and advice to adolescents faced with or anticipating conflicts with families and/or friends.
7. Encourage transition to adult health care when age-appropriate.

Pediatricians should be aware that the revelation of an adolescent's homosexuality (also called disclosure or "coming out") has the potential for intense family discord.[1,2,28] In many families, it precipitates physical and/or emotional abuse or even expulsion. The pediatrician can advise the adolescent to use certain language that may be helpful at the time of disclosure, such as "I am the same person, you just know one more thing about me now." However, there is no one disclosure technique that will preclude negative reactions. Parents, siblings, and other family members may require professional help to deal with their confusion, anger, guilt, and feelings of loss, and professionals who work with adolescents may be required to intervene on the adolescent's behalf. If the pediatrician has a relationship with the parents from ongoing primary care, he or she can be an important initial source of support and information. However, adolescents should be counseled to think carefully about the consequences of disclosure and to take their time in sharing information that could have many repercussions.[1]

With regard to parents of nonheterosexual adolescents, pediatricians are encouraged to:

1. Advise adolescents about whether, when, and how to disclose their nonheterosexuality to their parents. If unsure, assist the adolescent in finding a knowledgeable professional who can help.
2. Be knowledgeable about the process of disclosure.

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3. Be supportive of parents of adolescents who have disclosed that they are not heterosexual. Most states have chapters of Parents and Friends of Lesbians and Gays (PFLAG) to which interested families may be referred.
4. Remind parents and adolescents that gay and lesbian individuals can be successful parents themselves.[38–41]
5. Be prepared to refer parents if you do not feel personally comfortable accepting this responsibility.

COMMUNITY ADVOCACY

Despite AAP statements issued in 1983[42] and 1993[43] urging excellent clinical care for nonheterosexual adolescents, these patients still experience many risks to their physical and mental health and safety that occur outside the scope of usual office practice. Some pediatricians may wish to take a broader role in their communities to help decrease these risks. Pediatricians could model and provide opportunities for increasing awareness and knowledge of homosexuality and bisexuality among school staff, mental health professionals, and other community leaders. They can make themselves available as resources for community HIV and acquired immunodeficiency syndrome (AIDS) education and prevention activities. It is critical that schools find a way to create safe and supportive environments for students who are or wonder about being nonheterosexual or who have a parent or other family member who is nonheterosexual. Support from respected pediatricians can facilitate these efforts greatly. Pediatricians who choose to be active on these issues may wish to[2,28]:

1. Help raise awareness among school and community leaders of issues relevant to nonheterosexual youth.
2. Help with the discussion of when and how factual materials about sexual orientation should be included in school curricula and in school and community libraries.
3. Support the development and maintenance of school- and community-based support groups for nonheterosexual students and their friends and parents.
4. Support HIV and AIDS prevention and education efforts.
5. Develop and/or request continuing education opportunities for health care professionals related to issues of sexual orientation, nonheterosexual youth, and their families.

SUMMARY OF PHYSICIAN GUIDELINES

The AAP reaffirms the physician's responsibility to provide comprehensive health care and guidance in a safe and supportive environment for all adolescents, including nonheterosexual adolescents and young people struggling with issues of sexual orientation. Some pediatricians might choose to assume the additional role of advocating for nonheterosexual youth and their families in their communities. The deadly consequences of HIV and AIDS, the damaging effects of violence and ostracism, and the increased prevalence of adolescent suicidal behavior underscore the critical need to address and seek to prevent the major physical and mental health problems that confront nonheterosexual youths in their transition to a healthy adulthood.

REFERENCES

1. Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. New York, NY: Columbia University Press; 1998
2. Perrin EC. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic/Plenum Publishers; 2002
3. Sell RL, Becker JB. Sexual orientation data collection and progress toward Healthy People 2010. *Am J Public Health*. 2001;91:876–882
4. Friedman RC, Downey JI. Homosexuality. *N Engl J Med*. 1994;331:923–930
5. Stronski Huwiler SM, Remafedi G. Adolescent homosexuality. *Adv Pediatr*. 1998;45:107–144
6. Bell AP, Weinberg MS. *Homosexualities: A Study of Diversity Among Men and Women*. New York, NY: Simon and Shuster; 1978
7. Jay K, Young A. *The Gay Report: Lesbians and Gay Men Speak Out About Their Sexual Experiences and Lifestyles*. New York, NY: Summitt Books; 1979
8. Rowlett JD, Patel D, Greydanus DE. Homosexuality. In: Greydanus DE, Wolraich ML, eds. *Behavioral Pediatrics*. New York, NY: Springer-Verlag; 1992:37–54
9. Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Male*. Philadelphia, PA: WB Saunders Co; 1948
10. Remafedi G, Resnick M, Blum R, Harris L. Demography of sexual orientation in adolescents. *Pediatrics*. 1992;89:714–721
11. Savin-Williams RC. Theoretical perspectives accounting for adolescent homosexuality. *J Adolesc Health Care*. 1988;9:95–104
12. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Revised. Washington, DC: American Psychiatric Association; 1987
13. Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Female*. Philadelphia, PA: WB Saunders Co; 1953
14. Seidman SN, Reider RO. A review of sexual behavior in the United States. *Am J Psychiatry*. 1994;151:330–341
15. Sorenson RC. *Adolescent Sexuality in Contemporary America*. New York, NY: World Publishing; 1973

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16. Garofalo R, Wolf RC, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med.* 1999;153:487–493
17. Kreiss JL, Patterson DL. Psychosocial issues in primary care of lesbian, gay, bisexual, and transgender youth. *J Pediatr Health Care.* 1997;11: 266–274
18. Remafedi G. Adolescent homosexuality: psychosocial and medical implications. *Pediatrics.* 1987;79:331–337
19. Russell ST, Franz BT, Driscoll AK. Same-sex romantic attraction and experiences of violence in adolescence. *Am J Public Health.* 2001;91: 903–906
20. Garofalo R, Wolf RC, Kessel S, Palfrey SJ, DuRant RH. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics.* 1998;101:895–902
21. Valleroy LA, MacKellar DA, Karon JM, et al. HIV prevalence and associated risks in young men who have sex with men. *JAMA.* 2000; 284:198–204
22. Remafedi G, Farrow JA, Deisher RW. Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics.* 1991;87:869–875
23. Faulkner AH, Cranston K. Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *Am J Public Health.* 1998;88:262–266
24. Remafedi G, French S, Story M, Resnick MD, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health.* 1998;88:57–60
25. Remafedi G. Sexual orientation and youth suicide. *JAMA.* 1999;282: 1291–1292
26. French SA, Story M, Remafedi G, Resnick MD, Blum RW. Sexual orientation and prevalence of body dissatisfaction and eating disordered behaviors: a population-based study of adolescents. *Int J Eat Disord.* 1996;19:119–126
27. Savin-Williams RC, Cohen KM. *The Lives of Lesbians, Gays, and Bisexuals: Children to Adults.* Fort Worth, TX: Harcourt Brace College Publishing; 1996
28. Perrin EC. Pediatricians and gay and lesbian youth. *Pediatr Rev.* 1996; 17:311–318
29. American Academy of Pediatrics. Confidentiality in adolescent health care. *AAP News.* April 1989:9. Reaffirmed January 1993
30. Allen LB, Glicken AD, Beach RK, Naylor KE. Adolescent health care experience of gay, lesbian, and bisexual young adults. *J Adolesc Health.* 1998;23:212–220
31. Ryan C, Futterman D. Caring for gay and lesbian teens. *Contemp Pediatr.* 1998;15:107–130
32. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. Sexuality education for children and adolescents. *Pediatrics.* 2001;108: 498–502
33. American Academy of Pediatrics, Committee on Adolescence. Condom use by adolescents. *Pediatrics.* 2001;107:1463–1469
34. American Academy of Pediatrics, Committee on Adolescence. Sexually transmitted diseases. *Pediatrics.* 1994;94:568–572
35. American Academy of Pediatrics, Committee on Pediatric AIDS and Committee on Adolescence. Adolescents and human immunodeficiency virus infection: the role of the pediatrician in prevention and intervention. *Pediatrics.* 2001;107:188–190
36. American Academy of Pediatrics, Committee on Adolescence. Counseling the adolescent about pregnancy options. *Pediatrics.* 1998;101: 938–940
37. American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy—current trends and issues: 1998. *Pediatrics.* 1999;103: 516–520
38. Gold MA, Perrin EC, Futterman D, Friedman SB. Children of gay or lesbian parents. *Pediatr Rev.* 1994;15:354–358
39. Perrin EC. Children whose parents are lesbian or gay. *Contemp Pediatr.* 1998;15:113–130
40. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. Coparent or second-parent adoption by same-sex parents. *Pediatrics.* 2002;109:339–340
41. Benkov L. *Reinventing the Family: The Emerging Story of Lesbian and Gay Parents.* New York, NY: Crown Publishers; 1994
42. American Academy of Pediatrics, Committee on Adolescence. Homosexuality and adolescence. *Pediatrics.* 1983;72:249–250
43. American Academy of Pediatrics, Committee on Adolescence. Homosexuality and adolescence. *Pediatrics.* 1993;92:631–634

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AMERICAN ACADEMY OF PEDIATRICS

Ellen C. Perrin, MD, and the Committee on Psychosocial Aspects of Child and Family Health

Technical Report: Coparent or Second-Parent Adoption by Same-Sex Parents

ABSTRACT. **A growing body of scientific literature demonstrates that children who grow up with 1 or 2 gay and/or lesbian parents fare as well in emotional, cognitive, social, and sexual functioning as do children whose parents are heterosexual. Children's optimal development seems to be influenced more by the nature of the relationships and interactions within the family unit than by the particular structural form it takes.**

CURRENT SITUATION

Accurate statistics regarding the number of parents who are gay or lesbian are impossible to obtain. The secrecy resulting from the stigma still associated with homosexuality has hampered even basic epidemiologic research. A broad estimate is that between 1 and 9 million children in the United States have at least 1 parent who is lesbian or gay.[1]

Most individuals who have a lesbian and/or gay parent were conceived in the context of a heterosexual relationship. When a parent (or both parents) in a heterosexual couple "comes out" as lesbian or gay, some parents divorce and others continue to live as a couple. If they do decide to live separately, either parent may be the residential parent or children may live part-time in each home. Gay or lesbian parents may remain single or they may have same-sex partners who may or may not develop stepparenting relationships with the children. These families closely resemble stepfamilies formed after heterosexual couples divorce, and many of their parenting concerns and adjustments are similar. An additional concern for these parents is that pervasively heterosexist legal precedents have resulted in denial of custody and restriction of visitation rights to many gay and lesbian parents.

Increasing social acceptance of diversity in sexual orientation has allowed more gay men and lesbians to come out before forming intimate relationships or becoming parents. Lesbian and gay adults choose to become parents for many of the same reasons heterosexual adults do. The desire for children is a basic human instinct and satisfies many people's wish to leave a mark on history or perpetuate their family's story. In addition, children may satisfy people's desire to provide and accept love and nurturing from others and may provide some assurance of care and support during their older years.

Many of the same concerns that exist for heterosexual couples when they consider having children also face lesbians and gay men. All parents have concerns about time, finances, and the responsibilities of parenthood. They worry about how children will affect their relationship as a couple, their own and their children's health, and their ability to manage their new parenting role in addition to their other adult roles. Lesbians and gay men undertaking parenthood face additional challenges, including deciding whether to conceive or adopt a child, obtaining donor sperm or arranging for a surrogate mother (if conceiving), finding an accepting adoption agency (if adopting), making legally binding arrangements regarding parental relationships, creating a substantive role for the nonbiologic or nonadoptive parent, and confronting emotional pain and restrictions imposed by heterosexism and discriminatory regulations.

Despite these challenges, lesbians and gay men increasingly are becoming parents on their own or in the context of an established same-sex relationship. Most lesbians who conceive a child do so using alternative insemination techniques with a donor's sperm. The woman or women may choose to become pregnant using sperm from a completely anonymous donor, from a donor who has agreed to be identifiable when the child becomes an adult, or from a fully known donor (eg, a friend or a relative of the nonconceiving partner). Lesbians also can become parents by fostering or adopting children, as can gay men. These opportunities are increasingly available in most states and in many other countries, although they are still limited by legal statutes in some places.

A growing number of gay men have chosen to become fathers through the assistance of a surrogate mother who bears their child. Others have made agreements to be coparents with a single woman (lesbian or heterosexual) or a lesbian couple.[2–4] Still other men make arrangements to participate as sperm donors in the conception of a child (commonly with a lesbian couple), agreeing to have variable levels of involvement with the child but without taking on the responsibilities of parenting.

When a lesbian or a gay man becomes a parent through alternative insemination, surrogacy, or adoption, the biologic or adoptive parent is recognized within the legal system as having full and more or less absolute parental rights. Although the biologic or adoptive parent's partner may function as

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

PEDIATRICS (ISSN 0031 4005).

a coparent, he or she has no formal legal rights with respect to the child. Most state laws do not allow for adoption or guardianship by an unmarried partner unless the parental rights of the first parent are terminated. An attorney can prepare medical consent forms and nomination-of-guardian forms for the care of the child in the event of the legal parent's death or incapacity. These documents, however, do not have the force of an adoption or legal guardianship, and there is no guarantee that a court will uphold them. Some states recently have passed legislation that allows coparents to adopt their partner's children. Other states have allowed their judicial systems to determine eligibility for formal adoption by the coparent on a case-by-case basis. Coparent (or second-parent) adoption has important psychologic and legal benefits.

Historically, gay men and lesbians have been prevented from becoming foster parents or adopting children and have been denied custody and rights of visitation of their children in the event of divorce on the grounds that they would not be effective parents. Legal justifications and social beliefs have presumed that their children would experience stigmatization, poor peer relationships, subsequent behavioral and emotional problems, and abnormal psychosexual development. During the past 20 years, many investigators have tried to determine whether there is any empiric support for these assumptions.

RESEARCH EVIDENCE

The focus of research has been on 4 main topic areas. Investigators have concentrated on describing the attitudes and behaviors of gay and lesbian parents and the psychosexual development, social experience, and emotional status of their children.

Parenting Attitudes and Behavior, Personality, and Adjustment of Parents

Stereotypes and laws that maintain discriminatory practices are based on the assumption that lesbian mothers and gay fathers are different from heterosexual parents in ways that are important to their children's well-being. Empirical evidence reveals in contrast that gay fathers have substantial evidence of nurturance and investment in their paternal role and no differences from heterosexual fathers in providing appropriate recreation, encouraging autonomy,[5] or dealing with general problems of parenting.[6] Compared with heterosexual fathers, gay fathers have been described to adhere to stricter disciplinary guidelines, to place greater emphasis on guidance and the development of cognitive skills, and to be more involved in their children's activities.[7] Overall, there are more similarities than differences in the parenting styles and attitudes of gay and nongay fathers.

Similarly, few differences have been found in the research from the last 2 decades comparing lesbian and heterosexual mothers' self-esteem, psychologic adjustment, and attitudes toward child rearing.[8,9] Lesbian mothers fall within the range of normal psychologic functioning on interviews and psychologic assessments and report scores on standardized measures of self-esteem, anxiety, depression, and parenting stress indistinguishable from those reported by heterosexual mothers.[10]

Lesbian mothers strongly endorse child-centered attitudes and commitment to their maternal roles[11–13] and have been shown to be more concerned with providing male role models for their children than are divorced heterosexual mothers.[6,14] Lesbian and heterosexual mothers describe themselves similarly in marital and maternal interests, current lifestyles, and child-rearing practices.[14] They report similar role conflicts, social support networks, and coping strategies.[15,16]

Children's Gender Identity and Sexual Orientation

The gender identity of preadolescent children raised by lesbian mothers has been found consistently to be in line with their biologic sex. None of the more than 300 children studied to date have shown evidence of gender identity confusion, wished to be the other sex, or consistently engaged in cross-gender behavior. No differences have been found in the toy, game, activity, dress, or friendship preferences of boys or girls who had lesbian mothers, compared with those who had heterosexual mothers.

No differences have been found in the gender identity, social roles, or sexual orientation of adults who had a divorced homosexual parent (or parents), compared with those who had divorced heterosexual parents.[17–19] Similar proportions of young adults who had homosexual parents and those who had heterosexual parents have reported feelings of attraction toward someone of the same sex.[20] Compared with young adults who had heterosexual mothers, men and women who had lesbian mothers were slightly more likely to consider the possibility of having a same-sex partner, and more of them had been involved in at least a brief relationship with someone of the same sex,[10] but in each group similar proportions of adult men and women identified themselves as homosexual.

Children's Emotional and Social Development

Because most children whose parents are gay or lesbian have experienced the divorce of their biologic parents, their subsequent psychologic development has to be understood in that context. Whether they are subsequently raised by 1 or 2 separated parents and whether a stepparent has joined either of the biologic parents are important factors for children but are rarely addressed in research assessing outcomes for children who have a lesbian or gay parent.

The considerable research literature that has accumulated addressing this issue has generally revealed that children of divorced lesbian mothers grow up in ways that are very similar to children of divorced heterosexual mothers. Several studies comparing children who have a lesbian mother with children who have a heterosexual mother have failed to document any differences between such groups on personality measures, measures of peer group relationships, self-esteem, behavioral difficulties, academic success, or warmth and quality of family relationships.[9,11,15,16,20,21] Children's self-esteem has been

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shown to be higher among adolescents whose mothers (of any sexual orientation) were in a new partnered relationship after divorce, compared with those whose mothers remained single, and among those who found out at a younger age that their parent was homosexual, compared with those who found out when they were older.[22]

Prevalent heterosexism and stigmatization might lead to teasing and embarrassment for children about their parent's sexual orientation or their family constellation and restrict their ability to form and maintain friendships. Adult children of divorced lesbian mothers have recalled more teasing by peers during childhood than have adult children of divorced heterosexual parents.[23] Nevertheless, children seem to cope rather well with the challenge of understanding and describing their families to peers and teachers.

Children born to and raised by lesbian couples also seem to develop normally in every way. Ratings by their mothers and teachers have demonstrated children's social competence and the prevalence of behavioral difficulties to be comparable with population norms.[8,24] In fact, growing up with parents who are lesbian or gay may confer some advantages to children. They have been described as more tolerant of diversity and more nurturing toward younger children than children whose parents are heterosexual.[25,26]

In 1 study, children of heterosexual parents saw themselves as being somewhat more aggressive than did children of lesbians, and they were seen by parents and teachers as more bossy, negative, and domineering. Children of lesbian parents saw themselves as more lovable and were seen by parents and teachers as more affectionate, responsive, and protective of younger children, compared with children of heterosexual parents.[25,27] In a more recent investigation, children of lesbian parents reported their self-esteem to be similar to that of children of heterosexual parents and saw themselves as similar in aggressiveness and sociability.[15]

Recent investigations have attempted to discern factors that promote optimal well-being of children who have lesbian parents. The adjustment of children who have 2 mothers seems to be related to their parents' satisfaction with their relationship and specifically with the division of responsibility they have worked out with regard to child care and household chores.[28] Children with lesbian parents who reported greater relationship satisfaction, more egalitarian division of household and paid labor,[29] and more regular contact with grandparents and other relatives[30] were rated by parents and teachers to be better adjusted and to have fewer behavioral problems.

Children in all family constellations have been described by parents and teachers to have more behavioral problems when parents report more personal distress and more dysfunctional parent-child interactions. In contrast, children are rated as better adjusted when their parents report greater relationship satisfaction, higher levels of love, and lower interparental conflict regardless of their parents' sexual orientation. Children apparently are more powerfully influenced by family processes and relationships than by family structure.

SUMMARY

The small and nonrepresentative samples studied and the relatively young age of most of the children suggest some reserve. However, the weight of evidence gathered during several decades using diverse samples and methodologies is persuasive in demonstrating that there is no systematic difference between gay and nongay parents in emotional health, parenting skills, and attitudes toward parenting. No data have pointed to any risk to children as a result of growing up in a family with 1 or more gay parents. Some among the vast variety of family forms, histories, and relationships may prove more conducive to healthy psychosexual and emotional development than others.

Research exploring the diversity of parental relationships among gay and lesbian parents is just beginning. Children whose parents divorce (regardless of sexual orientation) are better adjusted when their parents have high self-esteem, maintain a responsible and amicable relationship, and are currently living with a partner.[22,31] Children living with divorced lesbian mothers have better outcomes when they learn about their mother's homosexuality at a younger age, when their fathers and other important adults accept their mother's lesbian identity, and perhaps when they have contact with other children of lesbians and gay men.[22,24] Parents and children have better outcomes when the daunting tasks of parenting are shared, and children seem to benefit from arrangements in which lesbian parents divide child care and other household tasks in an egalitarian manner[28] as well as when conflict between partners is low. Although gay and lesbian parents may not, despite their best efforts, be able to protect their children fully from the effects of stigmatization and discrimination, parents' sexual orientation is not a variable that, in itself, predicts their ability to provide a home environment that supports children's development.

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Sally E. A. Longstaffe, MD
Canadian Paediatric Society

CONSULTANTS
George J. Cohen, MD
Ellen C. Perrin, MD

STAFF
Karen Smith

REFERENCES

1. Laumann EO. *National Health and Social Life Survey*. Chicago, IL: University of Chicago and National Opinion Research Center; 1995
2. Barret RL, Robinson BE. *Gay Fathers*. Lexington, MA: Lexington Books; 1990
3. Bigner JJ, Bozett FW. Parenting by gay fathers. In: Bozett FW, Sussman MB, eds. *Homosexuality and Family Relations*. New York, NY: Harrington Park Press; 1990:155–175
4. Patterson CJ, Chan RW. Gay fathers and their children. In: Cabaj RP, Stein TS, eds. *Textbook of Homosexuality and Mental Health*. Washington, DC: American Psychiatric Press; 1996:371–393
5. Turner PH, Scadden L, Harris MB. Parenting in gay and lesbian families. *J Gay Lesbian Psychother*. 1990;1:55–66
6. Harris MB, Turner PH. Gay and lesbian parents. *J Homosex*. 1985;12: 101–113
7. Bigner JJ, Jacobsen RB. Adult responses to child behavior and attitudes toward fathering: gay and nongay fathers. *J Homosex*. 1992;23:99–112
8. Flaks DK, Ficher I, Masterpasqua F, Joseph G. Lesbians choosing motherhood: a comparative study of lesbian and heterosexual parents and their children. *Dev Psychol*. 1995;31:105–114
9. Green R, Mandel JB, Hotvedt ME, Gray J, Smith L. Lesbian mothers and their children: a comparison with solo parent heterosexual mothers and their children. *Arch Sex Behav*. 1986;15:167–184
10. Golombok S, Tasker F, Murray C. Children raised in fatherless families from infancy: family relationships and the socioemotional development of children of lesbian and single heterosexual mothers. *J Child Psychol Psychiatry*. 1997;38:783–791
11. Golombok S, Spencer A, Rutter M. Children in lesbian and single-parent households: psychosexual and psychiatric appraisal. *J Child Psychol Psychiatry*. 1983;24:551–572
12. Kirkpatrick M. Clinical implications of lesbian mother studies. *J Homosex*. 1987;14:201–211
13. Miller J, Jacobsen R, Bigner J. The child's home environment for lesbian vs heterosexual mothers: a neglected area of research. *J Homosex*. 1981; 7:49–56
14. Kirkpatrick M, Smith C, Roy R. Lesbian mothers and their children: a comparative survey. *Am J Orthopsychiatry*. 1981;51:545–551
15. Patterson CJ. Children of lesbian and gay parents. *Adv Clin Child Psychol*. 1997;19:235–282
16. Patterson CJ. Children of the lesbian baby boom: behavioral adjustment, self-concepts, and sex role identity. In: Greene B, Herek GM, eds. *Lesbian and Gay Psychology: Theory, Research, and Clinical Applications*. Thousand Oaks, CA: Sage Publications; 1994:156–175
17. Bailey JM, Bobrow D, Wolfe M, Mikach S. Sexual orientation of adult sons of gay fathers. *Dev Psychol*. 1995;31:124–129
18. Gottman JS. Children of gay and lesbian parents. *Marriage Fam Rev*. 1989;14:177–196
19. Patterson CJ. Children of lesbian and gay parents. *Child Dev*. 1992;63: 1025–1042
20. Tasker FL, Golombok S. *Growing Up in a Lesbian Family: Effects on Child Development*. New York, NY: Guilford Press; 1997
21. Allen M, Burrell N. Comparing the impact of homosexual and heterosexual parents on children: meta-analysis of existing research. *J Homosex*. 1996;32:19–35
22. Huggins SL. A comparative study of self-esteem of adolescent children of divorced lesbian mothers and divorced heterosexual mothers. *J Homosex*. 1989;18:123–135
23. Tasker F, Golombok S. Adults raised as children in lesbian families. *Am J Orthopsychiatry*. 1995;65:203–215
24. Patterson CJ. The family lives of children born to lesbian mothers. In: Patterson CJ, D'Augelli AR, eds. *Lesbian, Gay, and Bisexual Identities in Families: Psychological Perspectives*. New York, NY: Oxford University Press; 1998:154–176
25. Steckel A. Psychosocial development of children of lesbian mothers. In: Bozett FW, ed. *Gay and Lesbian Parents*. New York, NY: Praeger; 1987: 75–85
26. Stacey J, Biblarz TJ. (How) Does the sexual orientation of parents matter? *Am Sociol Rev*. 2001;66:159–183
27. Tasker F. Children in lesbian-led families: a review. *Clin Child Psychol Psychiatry*. 1999;4:153–166
28. Patterson CJ. Families of the lesbian baby boom: parents' division of labor and children's adjustment. *Dev Psychol*. 1995;31:115–123
29. Chan RW, Brooks RC, Raboy B, Patterson CJ. Division of labor among lesbian and heterosexual parents: associations with children's adjustment. *J Fam Psychol*. 1998;12:402–419
30. Patterson CJ, Hurt S, Mason CD. Families of the lesbian baby boom: children's contact with grandparents and other adults. *Am J Orthopsychiatry*. 1998;68:390–399
31. Emery RE. Interparental conflict and the children of discord and divorce. *Psychol Bull*. 1982;92:310–330

FactSHEET
American Psychiatric Association 1400 K St. NW, Washington, DC 20005

Gay, Lesbian and Bisexual Issues

"What is Sexual Orientation "?

"Sexual orientation" is a term frequently used to describe a person's romantic, emotional or sexual attraction to another person. A person attracted to another person of the same sex is said to have a homosexual orientation and may be called gay (both men and women) or lesbian. Individuals attracted to persons of the other sex are said to have a heterosexual orientation. Sexual orientation falls along a continuum and individuals who are attracted to both men and women are said to be bisexual. Sexual orientation is different from gender identity, which refers to the internal sense of whether one is male or female. Sexual orientation is a relatively new concept. In fact, although same sex behavior has always existed, the idea of a homosexual identity or a homosexual person is only about 100 years old.

The concept of sexual orientation refers to more than sexual behavior. It includes feelings as well as identity. Some individuals may identify themselves as gay lesbian or bisexual without engaging in any sexual activity. Some people believe that sexual orientation is innate and fixed; however, sexual orientation develops across a person's lifetime. Individuals maybe become aware at different points in their lives that they are heterosexual, gay, lesbian, or bisexual.

Is Homosexuality A Mental Disorder?

No. All major professional mental health organizations have gone on record to affirm that homosexuality is <u>not</u> a mental disorder. In 1973 the American Psychiatric Association's Board of Trustees removed homosexuality from its official diagnostic manual, *The Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM II)*. The action was taken following a review of the scientific literature and consultation with experts in the field. The experts found that homosexuality does not meet the criteria to be considered a mental illness.

What causes Homosexuality/Heterosexuality/Bisexuality?

No one knows what causes heterosexuality, homosexuality, or bisexuality. Homosexuality was once thought to be the result of troubled family dynamics or faulty psychological development. Those assumptions are now understood to have been based on misinformation and prejudice. Currently there is a renewed interest in searching for biological etiologies for homosexuality. However, to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality. Similarly, no specific psychosocial or family dynamic cause for homosexuality has been identified, including histories of childhood sexual abuse. Sexual abuse does not appear to be more prevalent in children who grow up to identify as gay, lesbian, or bisexual, than in children who identify as heterosexual.

(Revised May, 2000)

What is "Coming Out"?

"Coming out" is the term used to describe the experience in which a person identifies himself or herself as gay, lesbian or bisexual. Coming out is not a one-time event, but a lifelong process of identifying as gay, lesbian or bisexual to family friends and other significant members of one's social world. Each person's experience in coming out is unique and the process always stimulates anxiety as well as provides challenging possibilities for personal empowerment and emotional growth. There are many resources available to people coming out. See below for some of these resources.

Does Stigma Still Exist About Homosexuality?

Yes. Fears and misunderstandings about homosexuality are wide spread. They present daunting challenges to the development and maintenance of a positive self-image in gay, lesbian and bisexual persons and often to their families as well. "Homophobia" is a term that refers to the irrational fear and prejudice against homosexual persons.

Public opinion polls in the United States show that in the past twenty years, feelings toward gay men, lesbians and bisexuals have moved in a significantly positive direction. Nevertheless, when compared to other social groups homosexuals are still among the most stigmatized groups in the nation. Hate crimes are prevalent. Gay men and lesbians are still banned from serving openly in the US military service. Child custody decisions still frequently view gay and lesbian people as unfit parents. Gay and lesbian adolescents are often taunted and humiliated in their school settings. Many professional persons and employees in all occupations are still fearful of identifying as gay or lesbians in their work settings. Gay relationships are not recognized in any legal way.

What Position Has the American Psychiatric Association Taken Regarding This Stigma?

In 1992, the American Psychiatric Association, recognizing the power of the stigma against homosexuality, issued the following statement:

> "Whereas homosexuality per se implies no impairment in judgement, stability, reliability, or general social or vocational capabilities, the American Psychiatric Association calls on all international health organizations and individual psychiatrists in other countries, to urge the repeal in their own country of legislation that penalized homosexual acts by consenting adults in private. And further the APA calls on these organizations and individuals to do all that is possible to decrease the stigma related to homosexuality wherever and whenever it may occur."

Such organizational recognition of homophobia has been important in changing attitudes about homosexuality.

Is It Possible To Change One's Sexual Orientation ("Reparative Therapy")?

There is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation, nor is it included in the APA's Task Force Report, *Treatments of Psychiatric Disorders.* More importantly, altering sexual orientation is not an appropriate goal of psychiatric treatment. Some may seek conversion to heterosexuality because of the difficulties that they encounter as a member of a stigmatized group. Clinical experience indicates that those who have integrated their sexual orientation into a positive sense of self-function at a healthier psychological level than those who have

not. "Gay affirmative psychotherapy" may be helpful in the coming out process, fostering a positive psychological development and overcoming the effects of stigmatization. A position statement adopted by the Board in December 1998 said:

> The American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, which is based upon the assumption that homosexuality per se is a mental disorder, or based upon a prior assumption that the patient should change his/ her homosexual orientation." (See full position statements, below)

What Do the Parents of Gay Men/Lesbian/Bisexuals experience?

When a person "comes out " to their parents, it can be a very emotionally trying experience for all involved. Most parents are concerned for the welfare of their children, recognizing the difficulties posed by being a member of a stigmatized group. Often parents also fear rejection by their own family, friends, religious, or social groups. Fortunately, support exists for parents who are struggling to come to terms with their child's homosexuality. PFLAG (Parents and Friends of Lesbians and Gays) is an organization comprised of the families of gay men, lesbians, and bisexuals that provides information and assistance to parents and families. Family or individual psychotherapy can be very helpful in dealing with questions and concerns about a gay child. Other resources are listed below.

How Do the Children of Gay/Lesbians Parents Fare?

Many gay men and women are parents. For example, estimates of the numbers of lesbian mothers range from 1 to 5 million and with the number of children ranging from 6 to 14 million. Most gay parents conceived their children in prior heterosexual marriages. Recently an increasing number of gay parents have conceived children and raised them from birth either as single parents or in committed relationships. Often this is done through alternative insemination, adoption or through foster parenting. Numerous studies have shown that the children of gay parents are as likely to be healthy and well adjusted as children raised in heterosexual households. Children raised in gay or lesbian households do not show any greater incidence of homosexuality or gender identity issues than other children. Children raised in nontraditional homes with gay/lesbian parents can encounter some special challenges related to the ongoing stigma against homosexuality, but most children surmount these problems.

APA Position Statements Pertinent to Gay and Lesbian Issues

POSITION STATEMENTS ON THERAPIES FOCUSED ON ATTEMPTS TOCHANGE SEXUAL ORIENTATION ("REPARATIVE" OR "CONVERSION" THERAPIES)

The Board of Trustees of the American Psychiatric Association removed homosexuality from the DSM in 1973 after reviewing evidence that it was not a mental disorder. In 1987, ego-dystonic homosexuality was not included in the DSM-IIIR after a similar review.

The American Psychiatric Association does not currently have a formal position statement on treatments that attempt to change a person's sexual orientation, also known as Areparative or conversion therapy. There is an APA 1997 Fact Sheet on Homosexual and Bisexual Issues, which states that Athere is no published scientific evidence supporting the efficacy of Areparative therapy as a treatment to change one's sexual orientation.

The potential risks of Areparative therapy are great; including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. The American Psychiatric Association recognizes that in the course of ongoing psychiatric treatment, there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations, including the American Psychological Association, the National Association of Social Workers, and the American Academy of Pediatrics, have all made statements against Areparative therapy because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination on the basis of sexual orientation.

Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy, which is based upon the assumption that homosexuality *per se* is a mental disorder or based upon the *a priori* assumption that the patient should change his or her homosexual orientation.

(*December, 1998*)

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Although there is little scientific data about the patients who have undergone these treatments, it is still possible to evaluate the theories, which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologies homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by

anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality; it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determines "reparative" therapy's risks versus its benefits.

References

(1) National Association for Research and Treatment of Homosexuality, (1999), American Counseling Association Passes Resolution to Oppose Reparative Therapy. NARTH Website (http://www.narth.com/docs/acaresolution.html).

(2) Bayer, R. (1981), Homosexuality and American Psychiatry; The Politics of Diagnosis. New York: Basic Books.

(3) Haldeman, D. (1991), Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In Homosexuality: Research Implications for Public Policy, ed. J. C. Gonsiorek & J. D. Weinrich. Newbury Park, CA: Sage Publications, pp. 149-161.

(4) Haldeman, D. (1994), The practice and ethics of sexual orientation conversion therapy. J. of Consulting and Clin. Psychol., 62(2):221-227.

(5) Brown, L. S. (1996), Ethical concerns with sexual minority patients. In: Textbook of Homosexuality and Mental Health. ed. R. Cabaj & T. Stein. Washington, D.C.: American Psychiatric Press, pp. 897-916.

(6) Drescher, J. (1997), What needs changing? Some questions raised by reparative therapy practices. New York State Psychiatric Society Bulletin, 40(1):8-10.

(7) Duberman, M. (1991), Cures: A Gay Man•s Odyssey. New York: Dutton.

(8) White, M. (1994), Stranger at the Gate: To be Gay and Christian in America. New York: Simon & Schuster.

(9) Isay, R. (1996), Becoming Gay: The Journey to Self-Acceptance. New York: Pantheon.

(10) Freud, S. (1905), Three essays on the theory of sexuality. Standard Edition, 7:123-246. London: Hogarth Press, 1953.
(11) Rado, S. (1940), A critical examination of the concept of bisexuality. Psychosomatic Medicine, 2:459-467. Reprinted in Sexual Inversion: The Multiple Roots of Homosexuality, ed. J. Marmor. New York: Basic Books, 1965, pp. 175-189.

(12) Bieber, I., Dain, H., Dince, P., Drellich, M., Grand, H., Gundlach, R., Kremer, M., Rifkin, A., Wilbur, C., & Bieber T. (1962), Homosexuality: A Psychoanalytic Study. New York: Basic Books.

(13) Socarides, C. (1968), The Overt Homosexual. New York: Grune & Stratton.

(14) Ovesey, L. (1969), Homosexuality and Pseudohomosexuality. New York: Science House.

(15) Hatterer, L. (1970), Changing Homosexuality in the Male. New York: McGraw Hill.

(16) Moberly, E. (1983), Homosexuality: A New Christian Ethic. Cambridge, UK: James Clarke & Co.

(17) Harvey, J. (1987), The Homosexual Person: New Thinking in Pastoral Care. San Francisco, CA: Ignatius.

(18) Nicolosi, J. (1991), Reparative Therapy of Male Homosexuality: A New Clinical Approach. Northvale, NJ: Aronson.

(19) Kinsey, A., Pomeroy, W., & Martin, C. (1948), Sexual Behavior in the Human Male. Philadelphia, PA: Saunders.

(20) Kinsey, A., Pomeroy, W., & Martin, C. and Gebhard, P. (1953), Sexual Behavior in the Human Female. Philadelphia, PA: Saunders.

(21) Ford, C. & Beach, F. (1951), Patterns of Sexual Behavior. New York: Harper.

(22) Hooker, E. (1957), The adjustment of the male overt homosexual. J Proj Tech, 21:18-31.

(23) Bell, A .& Weinberg, M. (1978), Homosexualities: A Study of Diversity Among Men and Women. New York: Simon and Schuster.

(24) Bell, A., Weinberg, M. & Hammersmith S. (1981), Sexual Preference: Its Development in Men and Women. Bloomington, IN: Indiana University Press.

(25) LeVay, S. (1991), A difference in hypothalamic structure between heterosexual and homosexual men. Science, 253:1034-1037.

(26) Hamer, D., Hu, S., Magnuson, V., Hu, N. & Pattatucci, A. (1993), A linkage between DNA markers on the X-chromosome and male sexual orientation. Science, 261:321-327.

(27) Bem, D. (1996), Exotic becomes erotic: A developmental theory of sexual orientation. Psychol. Review, 103(2):320-335.

28) Marmor, J., ed. (1965), Sexual Inversion: The Multiple Roots of Homosexuality. New York: Basic Books.

(29) Mitchell, S. (1978), Psychodynamics, homosexuality, and the question of pathology. Psychiatry, 41:254-263.

(30) Marmor, J., ed. (1980), Homosexual Behavior: A Modern Reappraisal. New York: Basic Books.

(31) Mitchell, S. (1981), The psychoanalytic treatment of homosexuality: Some technical considerations. Int. Rev. Psycho-Anal., 8:63-80.

(32) Morgenthaler, F. (1984), Homosexuality Heterosexuality Perversion, trans. A. Aebi. Hillsdale, NJ: The Analytic Press, 1988.
(33) Lewes, K. (1988), The Psychoanalytic Theory of Male Homosexuality. New York: Simon and Schuster. Reissued as Psychoanalysis and Male Homosexuality (1995), Northvale, NJ: Aronson.

(34) Friedman, R.C. (1988), Male Homosexuality: A Contemporary Psychoanalytic Perspective. New Haven, CT: Yale University Press.

(35) Isay, R. (1989), Being Homosexual: Gay Men and Their Development. New York: Farrar, Straus and Giroux.

(36) O'Connor, N. & Ryan, J. (1993), Wild Desires and Mistaken Identities: Lesbianism & Psychoanalysis. New York: Columbia University.

(37) Domenici, T. & Lesser, R., eds. (1995) Disorienting Sexuality: Psychoanalytic Reappraisals of Sexual Identities. New York: Routledge.

(38) Magee, M. & Miller, D. (1997), Lesbian Lives: Psychoanalytic Narratives Old and New. Hillsdale, NJ: The Analytic Press.

(39) Drescher, J. (1998) Psychoanalytic Therapy and The Gay Man. Hillsdale, NJ: The Analytic Press.

(40) Boswell, J. (1980), Christianity, Social Tolerance and Homosexuality. Chicago, IL: University of Chicago Press.

(41) McNeil, J. (1993), The Church and the Homosexual, Fourth Edition. Boston, MA: Beacon.

(42) Pronk, P. (1993), Against Nature: Types of Moral Argumentation Regarding Homosexuality. Grand Rapids, MI: William B. Eerdmans.

(43) Boswell, J. (1994), Same-Sex Unions in Premodern Europe. New York: Villard Books.

(44) Helminiak, D. (1994), What the Bible Really Says About Homosexuality. San Francisco, CA: Alamo Press.

(45) Gomes, P. J. (1996). The Good Book: Reading the Bible with Mind and Heart. New York: Avon.

(46) Carrol, W. (1997), On being gay and an American Baptist minister. The InSpiriter, Spring, pp. 6-7,11._Appendix 1

(May 2000)

BIAS-RELATED INCIDENTS

Bias-related incidents, arising from racism, sexism, intolerance based on religion, ethnicity, and national/tribal origin, and anti-gay and -lesbian prejudice are widespread in society and continue to be a source of social disruption, individual suffering and trauma. These incidents are ubiquitous and occur in both urban and rural areas. Such hate-based incidents consist of acts of violence or harassment. These incidents result in emotional and physical trauma for individuals, as well as stigmatization of affected groups. Ethnic and cultural biases, vividly manifest in bias-related incidents, serve to frustrate the basic human need for dignity, resulting in despair and hopelessness among the victims that ultimately affect the whole nation.

The APA deplores such bias-related incidents. Moreover, the APA encourages its own members and components to take appropriate actions in helping to prevent such events, as well as to respond actively in the aftermath when such bias-related incidents occur locally.

(*December 1992*)

RIGHT TO PRIVACY

The American Psychiatric Association supports the right to privacy in matters such as birth control, reproductive choice, and adult consensual relations conducted in private, and it supports legislative, judicial, and regulatory efforts to protect and guarantee this right. (*December 1991*)

HOMOSEXUALITY and THE IMMIGRATION and NATURALIZATION SERVICE

The American Psychiatric Association strongly opposes all public and private discrimination against homosexuals in such areas as employment, housing, public accommodations, and licensing and immigration and naturalization decisions.

The Immigration and Naturalization Service, at least until 1990, considered homosexuality to be a mental illness and used this determination as a basis for the discriminatory exclusion of homosexual visitors and immigrants to the United States.

The American Psychiatric Association successfully opposed the continued inclusion of homosexuality as a mental illness by the Immigration and Naturalization Service. The APA believes that neither physical illness nor mental illness nor sexual orientation *per se* should be a basis for immigration or naturalization exclusion.

The American Psychiatric Association welcomes the changes presented in Title VI of the Immigration and Naturalization Act of 1990 and will be available to contribute to work intended to ensure that the immigration policies and practices of the United States are consistent with the relevant sections of that act. (*June 1991*)

HOMOSEXUALITY and ARMED SERVICES

APA, since 1973, has formally opposed all public and private discrimination against homosexuals in such areas as employment, housing, public accommodations and licensing. It follows that APA opposes exclusion and dismissal from the armed services on the basis of sexual orientation. Furthermore, APA asserts that no burden of proof of judgment, capacity, or reliability should be placed on homosexuals, which is greater than that imposed on any other persons within the armed services. (*December 1990*)

DISCRIMINATION BASED ON GENDER OR SEXUAL ORIENTATION

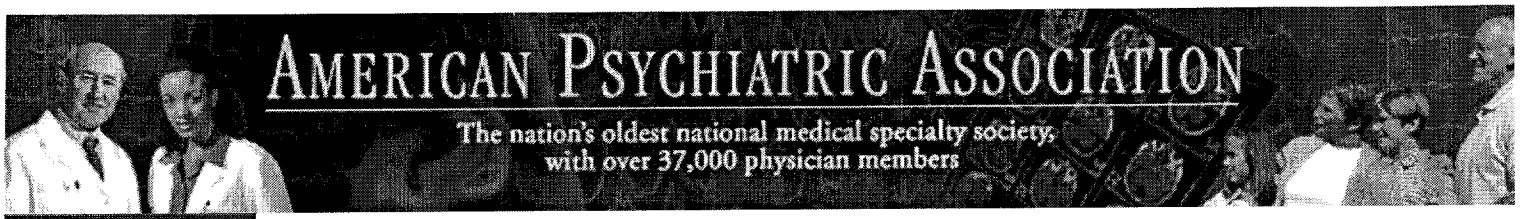
Irrational employment discrimination on the basis of gender and sexual orientation has received considerable attention in law, business, sociology, and, to a lesser degree, psychology. It is well known that sexual harassment and other forms of irrational gender-based discrimination have increased in recent years, and this trend is likely to continue because employees are increasingly aware of legal prohibitions against these and other forms of employment discrimination. While the psychiatric needs of self-identified discrimination victims have been under-recognized, both in and out of the workplace, psychiatrists can expect increasing consultations regarding these issues. It is important that psychiatrists appreciate and help others to understand the emotional consequences of irrational employment discrimination based on gender or sexual orientation. (*June 1988*)

National Association of Social Workers
750 First Street NE, Suite 700
Washington, DC 200002-4241
(202) 408-8600/ (800) 638-8799

National Gay and Lesbian Task Force
2320 17th Street Washington DC 20009
202-332-6483
Email: nglt@ngltf.org

Parents, Families and Friends of Lesbians and Gays
1101 14th street, NW Suite 1030 Washington, DC
(202-638-4200_
Email: info@PFLAG.org

Sexuality information and Education Council of the United States
13o w 42nd Street, Suite 350
New York, NY 10036
212-819-9770



Printer-Friendly Version

POSITION STATEMENT

COPP Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)

Approved by the Board of Trustees March 2000

Approved by the Assembly May 2000

Preamble

In December of 1998, the Board of Trustees issued a position statement that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversior therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation (Appendix 1). In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Associatior of Social Workers (1).

The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It augments rather than replaces the 1998 statement.

Position Statement

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Although there is little scientific data about the patients who have undergone these treatments, it is still possible to evaluate the theories, which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated olde psychoanalytic theories that pathologies homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality; it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determines "reparative" therapy's risks versus its benefits.

_References

(1) National Association for Research and Treatment of Homosexuality, (1999), American Counseling Association Passes Resolution to Oppose Reparative Therapy. NARTH Website (http://www.narth.com/docs/acaresolution.html).

(2) Bayer, R. (1981), Homosexuality and American Psychiatry; The Politics of Diagnosis. Nev York: Basic Books.

(3) Haldeman, D. (1991), Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In Homosexuality: Research Implications for Public Policy, ed. J. C. Gonsiorek & J. D. Weinrich. Newbury Park, CA: Sage Publications, pp. 149-161.

(4) Haldeman, D. (1994), The practice and ethics of sexual orientation conversion therapy. J of Consulting and Clin. Psychol., 62(2):221-227.

(5) Brown, L. S. (1996), Ethical concerns with sexual minority patients. In: Textbook of Homosexuality and Mental Health. ed. R. Cabaj & T. Stein. Washington, D.C.: American Psychiatric Press, pp.

897-916.

(6) Drescher, J. (1997), What needs changing? Some questions raised by reparative therapy practices. New York State Psychiatric Society Bulletin, 40(1):8-10.

(7) Duberman, M. (1991), Cures: A Gay Man€s Odyssey. New York: Dutton.

(8) White, M. (1994), Stranger at the Gate: To be Gay and Christian in America. New York: Simon & Schuster.

(9) Isay, R. (1996), Becoming Gay: The Journey to Self-Acceptance. New York: Pantheon.

(10) Freud, S. (1905), Three essays on the theory of sexuality. Standard Edition, 7:123-246 London: Hogarth Press, 1953.

(11) Rado, S. (1940), A critical examination of the concept of bisexuality. Psychosomatic Medicine, 2:459-467. Reprinted in Sexual Inversion: The Multiple Roots of Homosexuality, ed. J. Marmor. New

York: Basic Books, 1965, pp. 175-189.

(12) Bieber, I., Dain, H., Dince, P., Drellich, M., Grand, H., Gundlach, R., Kremer, M., Rifkin, A., Wilbur, C., & Bieber T. (1962), Homosexuality: A Psychoanalytic Study. New York: Basic Books.

(13) Socarides, C. (1968), The Overt Homosexual. New York: Grune & Stratton.

(14) Ovesey, L. (1969), Homosexuality and Pseudohomosexuality. New York: Science House

(15) Hatterer, L. (1970), Changing Homosexuality in the Male. New York: McGraw Hill.

(16) Moberly, E. (1983), Homosexuality: A New Christian Ethic. Cambridge, UK: James Clarke & Co.

(17) Harvey, J. (1987), The Homosexual Person: New Thinking in Pastoral Care. San Francisco, CA: Ignatius.

(18) Nicolosi, J. (1991), Reparative Therapy of Male Homosexuality: A New Clinical Approach. Northvale, NJ: Aronson.

(19) Kinsey, A., Pomeroy, W., & Martin, C. (1948), Sexual Behavior in the Human Male. Philadelphia, PA: Saunders.

(20) Kinsey, A., Pomeroy, W., & Martin, C. and Gebhard, P. (1953), Sexual Behavior in the Human Female. Philadelphia, PA: Saunders.

(21) Ford, C. & Beach, F. (1951), Patterns of Sexual Behavior. New York: Harper.

(22) Hooker, E. (1957), The adjustment of the male overt homosexual. J Proj Tech, 21:18-31.

(23) Bell, A .& Weinberg, M. (1978), Homosexualities: A Study of Diversity Among Men and Women. New York: Simon and Schuster.

(24) Bell, A., Weinberg, M. & Hammersmith S. (1981), Sexual Preference: Its Development in Men and Women. Bloomington, IN: Indiana University Press.

(25) LeVay, S. (1991), A difference in hypothalamic structure between heterosexual and homosexual men. Science, 253:1034-1037.

(26) Hamer, D., Hu, S., Magnuson, V., Hu, N. & Pattatucci, A. (1993), A linkage between DNA markers on the X-chromosome and male sexual orientation. Science, 261:321-327.

(27) Bem, D. (1996), Exotic becomes erotic: A developmental theory of sexual orientation. Psychol. Review, 103(2):320-335.

28) Marmor, J., ed. (1965), Sexual Inversion: The Multiple Roots of Homosexuality. New York: Basic Books.

(29) Mitchell, S. (1978), Psychodynamics, homosexuality, and the question of pathology. Psychiatry, 41:254-263.

(30) Marmor, J., ed. (1980), Homosexual Behavior: A Modern Reappraisal. New York: Basic Books.

(31) Mitchell, S. (1981), The psychoanalytic treatment of homosexuality: Some technical considerations. Int. Rev. Psycho-Anal., 8:63-80.

(32) Morgenthaler, F. (1984), Homosexuality Heterosexuality Perversion, trans. A. Aebi. Hillsdale, NJ: The Analytic Press, 1988.

(33) Lewes, K. (1988), The Psychoanalytic Theory of Male Homosexuality. New York: Simon and Schuster. Reissued as Psychoanalysis and Male Homosexuality (1995), Northvale, NJ: Aronson.

(34) Friedman, R.C. (1988), Male Homosexuality: A Contemporary Psychoanalytic Perspective. New Haven, CT: Yale University Press.

(35) Isay, R. (1989), Being Homosexual: Gay Men and Their Development. New York: Farrar, Straus and Giroux.

(36) O'Connor, N. & Ryan, J. (1993), Wild Desires and Mistaken Identities: Lesbianism & Psychoanalysis. New York: Columbia University.

(37) Domenici, T. & Lesser, R., eds. (1995) Disorienting Sexuality: Psychoanalytic Reappraisals of Sexual Identities. New York: Routledge.

(38) Magee, M. & Miller, D. (1997), Lesbian Lives: Psychoanalytic Narratives Old and New. Hillsdale, NJ: The Analytic Press.

(39) Drescher, J. (1998) Psychoanalytic Therapy and The Gay Man. Hillsdale, NJ: The Analytic Press.

(40) Boswell, J. (1980), Christianity, Social Tolerance and Homosexuality. Chicago, IL: University of Chicago Press.

(41) McNeil, J. (1993), The Church and the Homosexual, Fourth Edition. Boston, MA: Beacon.

(42) Pronk, P. (1993), Against Nature: Types of Moral Argumentation Regarding Homosexuality. Grand Rapids, MI: William B. Eerdmans.

(43) Boswell, J. (1994), Same-Sex Unions in Premodern Europe. New York: Villard Books.

(44) Helminiak, D. (1994), What the Bible Really Says About Homosexuality. San Francisco, CA: Alamo Press.

(45) Gomes, P. J. (1996). The Good Book: Reading the Bible with Mind and Heart. New York Avon.

(46) Carrol, W. (1997), On being gay and an American Baptist minister. The InSpiriter, Spring, pp. 6-7,11._Appendix 1

APA Position Statement on Psychiatric Treatment and Sexual Orientation Decembe 11, 1998

The Board of Trustees of the American Psychiatric Association removed homosexuality from the DSM in 1973 after reviewing the evidence that it was not a mental disorder. In 1987, ego-dystonic homosexuality was not included in the DSM-III-R after a similar review.

The American Psychiatric Association does not currently have a formal position statement on treatments that attempt to change a persons sexual orientation, also known as reparative or conversion therapy. There is an APA 1997 Fact Sheet on Homosexual and Bisexual Issues which states that there is no published scientific evidence supporting the efficacy of reparative therapy as a treatment to change ones sexual orientation.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing the effects of societal stigmatization discussed. The APA recognizes that in the course of ongoing psychiatric treatment there may be appropriate clinical indications for attempting to change sexual

behaviors.

Several major professional organizations including the American Psychological Association, the National Association of Social Workers and the American Academy of Pediatrics have all made statements against reparative therapy because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice and unethical treatment on a variety of issues including discrimination on the basis of sexual orientation.

Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality pe se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation.

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1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209-3901
phone: 703-907-7300 email: apa@psych.org

Answers to Your Questions About Sexual Orientation and Homosexuality

What Is Sexual Orientation?

Sexual Orientation is an enduring emotional, romantic, sexual or affectional attraction to another person. It is easily distinguished from other components of sexuality including biological sex, gender identity (the psychological sense of being male or female) and the social gender role (adherence to cultural norms for feminine and masculine behavior).

Sexual orientation exists along a continuum that ranges from exclusive homosexuality to exclusive heterosexuality and includes various forms of bisexuality. Bisexual persons can experience sexual, emotional and affectional attraction to both their own sex and the opposite sex. Persons with a homosexual orientation are sometimes referred to as gay (both men and women) or as lesbian (women only).

Sexual orientation is different from sexual behavior because it refers to feelings and self-concept. Persons may or may not express their sexual orientation in their behaviors.

What Causes a Person To Have a Particular Sexual Orientation?

There are numerous theories about the origins of a person's sexual orientation; most scientists today agree that sexual orientation is most likely the result of a complex interaction of environmental, cognitive and biological factors. In most people, sexual orientation is shaped at an early age. There is also considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality. In summary, it is important to recognize that there are probably many reasons for a person's sexual orientation and the reasons may be different for different people.

Is Sexual Orientation a Choice?

No, human beings can not choose to be either gay or straight. Sexual orientation emerges for most people in early adolescence without any prior sexual experience. Although we can choose whether to act on our feelings, psychologists do not consider sexual orientation to be a conscious choice that can be voluntarily changed.

Can Therapy Change Sexual Orientation?

No. Even though most homosexuals live successful, happy lives, some homosexual or bisexual people may seek to change their sexual orientation through therapy, sometimes pressured by the influence of family members or religious groups to try and do so. The reality

is that homosexuality is not an illness. It does not require treatment and is not changeable.

However, not all gay, lesbian, and bisexual people who seek assistance from a mental health professional want to change their sexual orientation. Gay, lesbian, and bisexual people may seek psychological help with the coming out process or for strategies to deal with prejudice, but most go into therapy for the same reasons and life issues that bring straight people to mental health professionals.

What About So-Called "Conversion Therapies"?

Some therapists who undertake so-called conversion therapy report that they have been able to change their clients' sexual orientation from homosexual to heterosexual. Close scrutiny of these reports however show several factors that cast doubt on their claims. For example, many of the claims come from organizations with an ideological perspective which condemns homosexuality. Furthermore, their claims are poorly documented. For example, treatment outcome is not followed and reported overtime as would be the standard to test the validity of any mental health intervention.

The American Psychological Association is concerned about such therapies and their potential harm to patients. In 1997, the Association's Council of Representatives passed a resolution reaffirming psychology's opposition to homophobia in treatment and spelling out a client's right to unbiased treatment and self-determination. Any person who enters into therapy to deal with issues of sexual orientation has a right to expect that such therapy would take place in a professionally neutral environment absent of any social bias.

Is Homosexuality a Mental Illness or Emotional Problem?

No. Psychologists, psychiatrists and other mental health professionals agree that homosexuality is not an illness, mental disorder or an emotional problem. Over 35 years of objective, well-designed scientific research has shown that homosexuality, in and itself,is not associated with mental disorders or emotional or social problems. Homosexuality was once thought to be a mental illness because mental health professionals and society had biased information. In the past the studies of gay, lesbian and bisexual people involved only those in therapy, thus biasing the resulting conclusions. When researchers examined data about these people who were not in therapy, the idea that homosexuality was a mental illness was quickly found to be untrue.

In 1973 the American Psychiatric Association confirmed the importance of the new, better designed research and removed homosexuality from the official manual that lists mental and emotional disorders. Two years later, the American Psychological Association passed a resolution supporting the removal. For more than 25 years, both associations have urged all mental health professionals to help dispel the stigma of mental illness that some people still associate with homosexual orientation.

Can Lesbians, Gay Men, and Bisexuals Be Good Parents?

Yes. Studies comparing groups of children raised by homosexual and by heterosexual parents find no developmental differences between the two groups of children in four critical areas: their intelligence, psychological adjustment, social adjustment, and popularity with friends. It is also important to realize that a parent's sexual orientation does not dictate his or her children's.

Another myth about homosexuality is the mistaken belief that gay men have more of a tendency than heterosexual men to sexually molest children. There is no evidence to suggest that homosexuals are more likely than heterosexuals to molest children.

Why Do Some Gay Men, Lesbians and Bisexuals Tell People About Their Sexual Orientation?

Because sharing that aspect of themselves with others is important to their mental health. In fact, the process of identity development for lesbians, gay men and bisexuals called "coming out", has been found to be strongly related to psychological adjustment—the more positive the gay, lesbian, or bisexual identity, the better one's mental health and the higher one's self-esteem.

Why Is the "Coming Out" Process Difficult for Some Gay, Lesbian and Bisexual People?

For some gay and bisexual people the coming out process is difficult, for others it is not. Often lesbian, gay and bisexual people feel afraid, different, and alone when they first realize that their sexual orientation is different from the community norm. This is particularly true for people becoming aware of their gay, lesbian, or bisexual orientation as a child or adolescent, which is not uncommon. And, depending on their families and where they live, they may have to struggle against prejudice and misinformation about homosexuality. Children and adolescents may be particularly vulnerable to the deleterious effects of bias and stereotypes. They may also fear being rejected by family, friends,co-workers, and religious institutions. Some gay people have to worry about losing their jobs or being harassed at school if their sexual orientation became well known. Unfortunately, gay, lesbian and bisexual people are at a higher risk for physical assault and violence than are heterosexuals. Studies done in California in the mid 1990s showed that nearly one-fifth of all lesbians who took part in the study and more than one-fourth of all gay men who participated had been the victim of a hate crime based on their sexual orientation. In another California study of approximately 500 young adults, half of all the young men participating in the study admitted to some form of anti-gay aggression from name-calling to physical violence.

What Can Be Done to Overcome the Prejudice and Discrimination the Gay Men, Lesbians, and Bisexuals Experience?

Research has found that the people who have the most positive attitudes toward gay men, lesbians and bisexuals are those who say they know one or more gay, lesbian or bisexual person well—often as a friend or co-worker. For this reason, psychologists believe negative attitudes toward gay people as a group are prejudices that are not grounded in actual experiences but are based on stereotypes and prejudice.

Furthermore, protection against violence and discrimination is very important, just as it is for other minority groups. Some states include violence against an individual on the basis of his or her sexual orientation as a "hate crime" and 10 U.S. states have laws against discrimination on the basis of sexual orientation.

Why is it Important for Society to be Better Educated About Homosexuality?

Educating all people about sexual orientation and homosexuality is likely to diminish anti-gay prejudice. Accurate information about homosexuality is especially important to young people who are first discovering and seeking to understand their sexuality—whether homosexual, bisexual, or heterosexual. Fears that access to such information will make more people gay have no validity—information about homosexuality does not make someone gay or straight.

Are All Gay and Bisexual Men HIV Infected?

No. This is a commonly held myth. In reality, the risk of exposure to HIV is related to a person's behavior, not their sexual orientation. What's important to remember about HIV/AIDS is it is a preventable disease through the use of safe sex practices and by not using drugs.

Where Can I Find More Information About Homosexuality?

APA Lesbian, Gay, and Bisexual Concerns Program
750 First Street, NE. Washington, DC 20002
Email: LGBC

National Gay and Lesbian Task Force
2320 17th St. Washington, DC 20009 (202) 332-6483
Email: NGLTF

Parents, Families and Friends of Lesbians and Gays
1726 M Street, NW, Suite 400, Washington, DC 20036 (202) 467-8180
Email: PFLAG

Sexuality Information and Education Council of the United States
130 W 42nd St., Ste. 350 New York, NY 10036 (212)-819-9770
Email: SIECUS

Office of Public Affairs
750 First Street, NE • Washington, DC • 20002-4242
Phone: 202-336-5700 • TDD/TTY: 202-336-6123
Fax: 202-336-5708 • Email

Just the Facts About
Sexual Orientation & Youth:
A Primer for Principals, Educators and School Personnel

was developed and is endorsed by the following organizations:

- American Academy of Pediatrics
- American Counseling Association
- American Association of School Administrators
- American Federation of Teachers
- American Psychological Association
- American School Health Association
- Interfaith Alliance Foundation
- National Association of School Psychologists
- National Association of Social Workers
- National Education Association

Controversies in our society about homosexuality are increasingly involving schools. As principals, educators, and school personnel, you need good information that will help guide you through these controversies. This factsheet has been developed by a group of education, health, mental health, and religious organizations that all share a concern for the health and education of all students in schools, including lesbian, gay, and bisexual students. We know you also share this concern—that all students deserve an opportunity for learning and healthy development in a safe and supportive environment.

The reason for publishing this factsheet now is the recent upsurge in aggressive promotion of "reparative therapy" and "transformational ministry." "Reparative therapy" refers to psychotherapy to eliminate individuals' sexual desires for members of their own gender. "Transformational ministry" refers to the use of religion to eliminate those desires. Since mid-1998, a number of organizations have invested significant resources in the promotion of "reparative therapy" and "transformational ministry" in the press, in conferences targeting educators, and in television and newspaper ads. This factsheet provides information from physicians, counselors, social workers, psychologists, legal experts, and educators who are knowledgeable about the development of sexual orientation in youth and the issues raised by "reparative therapy" and "transformational ministry." We hope that you and others who care about and work with youth will review the

factual and scientific information provided herein and weigh it carefully in considering how to respond appropriately to controversies about homosexuality when they arise in your school.

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Sexual Orientation Development

Sexual orientation is one component of a person's identity, which is made up of many other components, such as culture, ethnicity, gender, and personality traits. Sexual orientation is an enduring emotional, romantic, sexual, or affectional attraction that a person feels toward another person. Sexual orientation falls along a continuum. In other words, someone does not have to be exclusively homosexual or heterosexual, but can feel varying degrees of attraction for both genders. Sexual orientation develops across a person's lifetime—different people realize at different points in their lives that they are heterosexual, gay, lesbian, or bisexual.

Sexual behavior does not necessarily equate to sexual orientation. Many adolescents—as well as many adults—may identify themselves as homosexual or bisexual without having had any sexual experience. Other young people have had sexual experiences with a person of the same gender, but do not consider themselves to be gay, lesbian, or bisexual. This is particularly relevant during adolescence because it is a time for experimentation—a hallmark of this developmental period.

Gay, lesbian, and bisexual adolescents follow a develop-mental path that is both similar to and quite different from that followed by heterosexual adolescents. All teenagers face certain developmental challenges, such as developing social skills, thinking about career choices, and fitting into a peer group. Gay, lesbian, and bisexual youth must also cope with prejudiced, discriminatory, and violent behavior and messages in their families, schools, and communities. Such behavior and messages negatively affect the health, mental health and education of lesbian, gay, and bisexual young people. These students are more likely than heterosexual students to report missing school due to fear, being threatened by other students, and having their property damaged at school.[1] The promotion of "reparative therapy" and "transformational ministry" is likely to exacerbate the risk of harassment, harm, and fear.

For these reasons, the experience of gay, lesbian, and bisexual teenagers is often one of isolation, fear of stigmatization, and lack of peer or familial support. Gay, lesbian, and bisexual youth have few opportunities for observing positive modeling by adults due to the general cultural bias that makes gay, lesbian, and bisexual people largely invisible. It is this isolation and lack of support that accounts in part for the higher rates of emotional distress,[2] suicide attempts,[3] and risky sexual behavior and substance use [4] that gay, lesbian, and bisexual students report compared to heterosexual students. Because of their legitimate fear of being harassed or hurt, gay, lesbian, or bisexual youth are less likely to ask for help. Thus, it is important that their environments be as open and accepting as possible, so these young people will feel comfortable sharing their thoughts and concerns. To be able to provide an accepting environment, school personnel need to understand the nature of sexual orientation development and be supportive of healthy development for all youth.

"Coming out" refers to the process of acknowledging one's gay, lesbian, or bisexual attractions and identity to oneself and disclosing them to others. This process is different for every teenager; however, most adolescents disclose their sexual orientation to others in the following order: other gay, lesbian, and bisexual peers, close heterosexual peers, close family members, and finally, parents.[5]

Many people may wonder why gay, lesbian, and bisexual teenagers and adults feel the need to "come out," i.e., disclose their sexual orientation to others. This is actually the expression of a normal tendency to want to share personal information about oneself with important others, and should be treated as such by those around the gay, lesbian, or bisexual adolescent. It is healthy for teenagers to share with friends and families their latest crush or how they spent their weekend. This process, however, is often quite difficult for the gay, lesbian, or bisexual adolescent, because there is a strong (and well-founded) fear of being rejected by others.

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Reparative Therapy

The term "reparative therapy" refers to psychotherapy aimed at eliminating homosexual desires and is used by people who do not think homosexuality is one variation within human sexual orientation, but rather still believe homosexuality is a mental disorder. The most important fact about "reparative therapy," also sometimes known as "conversion" therapy, is that it is based on an understanding of homosexuality that has been rejected by all the major health and mental health professions. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 477,000 health and mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus there is no need for a "cure."

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association and defining the standard of the field, does not include homosexuality as a mental disorder. All other major health professional organizations have supported the American Psychiatric Association in its declassification of homosexuality as a mental disorder in 1973. Thus, the idea that homosexuality is a mental disorder or that the emergence of same-gender sexual desires among some adolescents is in any way abnormal or mentally unhealthy has no support among health and mental health professional organizations.

Despite the unanimity of the health and mental health professions on the normality of homosexuality, the idea of "reparative therapy" has recently been adopted by conservative organizations and aggressively promoted in the media. Because of this aggressive promotion of "reparative therapy," a number of the health and mental health professional organizations have recently issued public statements about "reparative therapy" as well.

The American Academy of Pediatrics in its policy statement on Homosexuality and Adolescence states: *Confusion about sexual orientation is not unusual during adolescence. Counseling may be helpful for young people who are uncertain about their sexual orientation or for those who are uncertain*

about how to express their sexuality and might profit from an attempt at clarification through a counseling or psychotherapeutic initiative. Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation.[6]

The American Counseling Association has adopted a resolution that states that it: *opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation; and supports the dissemination of accurate information about sexual orientation, mental health, and appropriate interventions in order to counteract bias that is based on ignorance or unfounded beliefs about same-gender sexual orientation.*[7] Further, at its 1999 World Conference, ACA adopted a position opposing the promotion of "reparative therapy" as a "cure" for individuals who are homosexual.[8]

The American Psychiatric Association in its position statement on Psychiatric Treatment and Sexual Orientation states: *The potential risks of "reparative therapy" are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone "reparative therapy" relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.*[9]

The American Psychological Association in its Resolution on Appropriate Therapeutic Responses to Sexual Orientation, which is also endorsed by the National Association of School Psychologists, states: *That the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation.*[10]

The National Association of Social Workers in its Policy Statement on Lesbian, Gay and Bisexual Issues: *endorses policies in both the public and private sectors that ensure nondiscrimination; that are sensitive to the health and mental health needs of lesbian, gay, and bisexual people; and that promote an understanding of lesbian, gay, and bisexual cultures. Social stigmatization of lesbian, gay, and bisexual people is widespread and is a primary motivating factor in leading some people to seek sexual orientation changes.*[11] *Sexual orientation conversion therapies assume that homosexual orientation is both pathological and freely chosen. No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful.*[12] *NASW believes social workers have the responsibility to clients to explain the prevailing knowledge concerning sexual orientation and the lack of data reporting positive outcomes with reparative therapy. NASW discourages social workers from providing treatments designed to change sexual orientation or from referring practitioners or programs that claim to do so.*[13]

As these statements make clear, health and mental health professional organizations do not support efforts to change young people's sexual orientation through "reparative therapy" and have raised serious concerns about its potential to do harm. Many of the professional associations listed in the Resources section at the end of this factsheet are able to provide helpful information and local contacts to assist school administrators, health and mental health professionals, educators, teachers, and parents in dealing with school controversies in their communities.

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Transformational Ministries

Transformational ministry" is a term used to describe the use of religion to eliminate homosexual desires. While "reparative therapy" relies on secular approaches, "transformational ministry" takes the approach that "freedom from homosexuality is possible through repentance and faith in Jesus Christ as Savior and Lord."[14] While there is some diversity within the movement, most "transformational ministries" adhere to a belief that "upholds heterosexuality as God's creative intent for humanity, and subsequently views homosexual expression as outside God's will."[15] The "transformational ministry" movement, which began in the early 1970s, has gained more visibility in the media recently through the efforts of Christian publishers and conservative political organizations.

The most important fact about "transformational ministry" is that its view of homosexuality is not representative of the views of all people of faith. Many deeply religious people and a number of religious congregations and denominations are supportive and accepting of lesbian, gay, and bisexual people and their right to be protected from the discriminatory acts of others. For example, the following organizations have endorsed passage of the Employment Non-Discrimination Act, which would prohibit employment discrimination based on sexual orientation:

American Ethical Union, American Friends Service Committee, American Jewish Committee, American Jewish Congress, Church of the Brethren, Church Women United, Dignity/USA, Episcopal Church, Evangelical Lutheran Church in America, Hadassah, WZOA, The Interfaith Alliance, Jewish Women International, National Council of Churches of Christ, USA, National Council of Jewish Women, North Georgia United Methodists, Presbyterian Church (USA), Religious Action Center of Reform Judaism, Unitarian Universalist Association, United Church of Christ, United Methodist Church, Women of Reform Judaism, Young Women's Christian Association

Although "transformational ministry" promotes the message that religious faith and acceptance of gay, lesbian, and bisexual sexuality are incompatible, that message is countered by the large number of outspoken clergy and people of faith who promote love and acceptance.

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Relevant Legal Principles

As targets of pressure to include information about "reparative therapy" and "transformational ministry" in their schools, public school officials should be aware of general legal principles concerning the rights of their lesbian, gay, and bisexual students. This aware-ness is important both because of the risk that these "treatments" may cause harm to young people and because of the potential legal liability for school officials. A number of federal, state and local laws protect gay and lesbian students from discrimination and similar harms. Other laws, such as "personal injury" laws, apply generally to all people who suffer significant physical or emotional injuries. But two important principles from the U.S. Constitution should be mentioned here because they apply to every public school in the country. These two principles are (1) the separation of church and state and (2) the entitlement of all persons to equal protection under the law.

Like all students, those who are or are perceived to be lesbian, gay, or bisexual are protected by the Establishment Clause of the First Amendment, which, among other things, requires the separation of church and state. For example, public schools may not promote religion, endorse particular religious beliefs or seek to impose such beliefs on students. Also, a guidance counselor in a public school context may not attempt to persuade a gay, lesbian or bisexual student of the religious belief of some that homosexuality is a sin, or otherwise seek to impose a negative religious view of being gay, lesbian or bisexual on the student. Because of the religious nature of "transformational ministry," endorsement or pro-motion of such ministry by officials or employees of a public school district in a school-related context could raise constitutional problems.

Lesbian, gay, and bisexual students, like all other students, are also protected by the 14th Amendment's requirement of equal treatment under the law. The Supreme Court has made clear that public officials may not impose discriminatory burdens or unequal treatment on gays and lesbians because of the public's animosity towards them.[16] In the public school setting, this means, among other things, that a school district must protect students from anti-gay harassment just as it protects students from other kinds of harassment. In 1996, in the Nabozny case, a Wisconsin student received a settlement of nearly one million dollars after a jury finding that his school had failed to stop repeated anti-gay harassment directed at him but had responded appropriately to other types of in-school harassment directed at others.[17]

The legal mandate of equality for gay and non-gay students alike is not limited to circumstances of harassment; it applies to all decisions a public school official might make that would treat lesbian, gay, and bisexual students differently. School officials should follow the law by ensuring that the factor of real or perceived sexual orientation does not result in a decision that treats these students as less than equal to other students, or that otherwise discriminates against gay, lesbian, and bisexual students on the basis of sexual orientation. For example, students around the country are increasingly forming "Gay-Straight Alliances" in schools. The legal mandate of equality is reflected (along with federal statutory protections) in school officials' decisions to treat "Gay-Straight Alliances" on an equal footing with other student groups.

Finally, it is important to note that public schools may determine, as part of their instructional activity, not to disseminate information to students when that information is not well-founded, or is inadequately researched, scientifically unsound or biased in some way. As clearly illustrated by the foregoing discussion

of concerns and policies of health and mental health professionals, school officials should be deeply concerned about the validity and bias of materials or presentations that promote a change to a person's sexual orientation as a "cure" or suggest that being gay, lesbian, or bisexual is unhealthy. School officials routinely make such judgments in determining which educational and instructional materials to use in their schools.

These general legal principles, supplemented by consultation with the school's legal counsel, should be helpful in the important and sometimes difficult decisions that educators must make in order to serve all students—including those who are gay, lesbian or bisexual.

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Endnotes

1. Garofalo, R, Wolf, R.C., Kessel, S., Palfrey, J., & Du Rant, R.H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*, 101(5), 895-902.
return to text

2. Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.S., Jones, J., Tabor, J., Beuhring, T., Sieving, R.E., Shew, M., Ireland, M., Bearing, L.H., & Udry, J.R., (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, 278(10), 823-832.
return to text

3. Garofalo, et al. 1998; Remafedi, G., Frendh, S., Story, M., Resnick, M.D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, 88 (1), 57-60.
return to text

4. Garofalo et al. 1998; Resnick et al. 1997.
return to text

5. Ryan, C., & Futterman, D. (1997). Lesbian and gay youth: Care and counseling. *Adolescent Medicine: State of the Art Reviews*, 8(2). [Also published in 1998 by Columbia University Press.]
return to text

6. Policy Statement: Homosexuality and Adolescence, American Academy of Pediatrics, 1993.
return to text

7. Resolution adopted by American Counseling Association Governing Council, March 1998.
return to text

8. Action by American Counseling Association Governing Council, April 1999.
return to text

9. Position Statement: Psychiatric Treatment and Sexual Orientation,

American Psychiatric Association, 1998.
return to text

10. Resolution on Appropriate Therapeutic Responses to Sexual Orientation, American Psychological Association, 1997.
return to text

11. Haldeman, D.C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Counseling and Clinical Psychology*, 62(2), 221-227.
return to text

12. Davison, G.C. (1991). Constructionism and morality in therapy for homosexuality. In J.C. Gonsiorek & J.D. Weinrich, *Homosexuality: Research implications for public policy*. Newbury Park, CA: Sage Publications; Gonsiorek, J.C., & Weinrich, J.D. (1991). *Homosexuality: Research implications for public policy*. Newbury Park, CA: Sage Publications; Haldeman, D.C. (1994).
return to text

13. "Policy Statement: Lesbian, Gay, and Bisexual Issues. Approved by Delegate Assembly, August 1996. Social Work Speaks, 4th ed., NASW, 1997
return to text

14. From the website of Exodus International, a "transformational ministry"
return to text

15. Exodus International
return to text

16. Romer v. Evans, 116 S. Ct. 1620 (1996)
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17. Nabozny v. Podlesny, 92 F. 3d 446 (7th Cir. 1996)
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Resources

This factsheet provides some basic information that will help you prepare for controversies that your school may experience in the future. You may, however, want to go beyond the information given in this factsheet. Many schools have begun to work to improve counseling, health, mental health and psychological services, curriculum, and climate so that the educational and health needs of lesbian, gay, bisexual, transgender, and questioning youths are better served. The following resources will be helpful if you or your staff undertake such efforts.

Federal Agencies

Department of Education

Office of Civil Rights

Mary E. Switzer Building
330 C Street, SW
Washington, DC 20202
Phone: (202) 205-5413; 1-800-421-3491
Fax: (202) 205-9862
TDD: (202) 205-5166
www.ed.gov/offices/OCR

This office has the mission to ensure equal access to education and to promote educational excellence throughout the nation through vigorous enforcement of civil rights. They have an extensive list of publications at their website and offer other technical assistance through the contact information listed above.

Safe and Drug Free Schools Program
Office of Elementary and Secondary Education
400 Maryland Avenue, SW
Washington, DC 20202
Phone: (202) 401-0113
Fax: (202) 205-0310
www.ed.gov/offices/OESE

This office is charged with assisting the Department of Education to reach the seventh national education goal - that by the year 2000 all schools will be free of drugs and violence and the unauthorized presence of firearms and alcohol and will offer a disciplined environment that is conducive to learning. It has several publications available through the contact information cited above, including the website.

Department of Health and Human Services

Health Resources and Services Administration
Bureau of Primary Health Care
Division of Programs for Special Populations
4350 East-West Highway
Bethesda, MD 20814
Phone: (301) 594-4100
www.bphc.hrsa.dhhs.gov/

In 1994, the HRSA Division of Programs for Special Populations convened a conference on the primary health care and prevention needs of lesbian, gay, and bisexual youth. Out of that conference evolved a health and mental health provider guide that is also accessible for educators and parents. (Ryan, C. and Futterman, D., Lesbian and Gay Youth: Care and Counseling, Columbia University Press 1998)

Centers for Disease Control and Prevention
National Center for Chronic
Disease Prevention and Health Promotion
Division of Adolescent and School Health
4770 Buford Highway NE
Atlanta, GA 30341-3717
Office: (770) 488-3251
Fax: (770) 488-3110
www.cdc.gov/nccdphp/dash/

The CDC Division of Adolescent and School Health (DASH) has identified gay, lesbian, bisexual, transgender, and questioning adolescents as a priority population for HIV infection. One of DASH's Youth in High Risk Situations Work Groups is focused on gay, lesbian, bisexual, transgender, and questioning youth.

Non-Governmental Organizations

Mental Health Organizations

American Counseling Association (ACA)
5999 Stevenson Avenue
Alexandria, VA 22304-3300
Office: (703) 823-9800
Fax: (703) 823-0252
www.counseling.org

American Psychiatric Association (APA)
1400 K Street, NW
Washington, DC 20005
Office: (202) 682-6097
Fax: (202) 682-6352
www.psych.org

American Psychological Association (APA)
Lesbian, Gay, & Bisexual Concerns Office
750 1st Street, NE
Washington, DC 20002-4242
Office: (202) 336- 6041
Fax: (202) 336-6040
www.apa.org/pi/lgbc/

Association of Gay and Lesbian Psychiatrists (AGLP)
4514 Chester Avenue
Philadelphia, PA 19143-3707
Office: (215) 222-2800
Fax: (215) 222-3881
www.aglp.org

National Association of School Psychologists (NASP)
4340 East West Highway
Suite 402
Bethesda, MD 20814
Office: (301) 657-0270 x223
Fax: (301) 657-0275
www.naspweb.org

National Association of Social Workers (NASW)
National Committee on Lesbian, Gay, & Bisexual Issues
750 First Street, NE, Suite 700
Washington, DC 20002-4241
Office: (202) 408-8600
Fax: (202) 336-8310
www.socialworkers.org

Health Organizations American Academy of Pediatrics (AAP)
Division of Child and Adolescent Health
141 Northwest Point Blvd.
Elk Grove Village, IL 60007
Office: (847) 228-5005
Fax: (847) 228-5097
www.aap.org

American Medical Association (AMA)
Child and Adolescent
Health Program
515 North State Street, 8th Fl.
Chicago, IL 60610
Office: (312) 464-5315
Fax: (312) 464-5842
www.ama-assn.org

National Association of School Nurses, Inc.
P.O. Box 1300
Scarborough, ME 04070-1300
Phone: (207) 883-2117
Fax: (207) 883-2683
www.NASN.org

Education Organizations

American Association of School Administrators (AASA)
1801 North Moore Street
Arlington, VA 22209
Phone: (703) 528-0700
Fax: (703) 841-1543
www.aasa.org

American Federation of Teachers (AFT)
Human Rights & Community
Relations Department
555 New Jersey Avenue, NW
Washington, DC 20001-2079
Office: (202) 879-4434
Fax: (202) 393-8648
www.aft.org

American School Health Association (ASHA)
7263 State Route 43
P.O. Box 708
Kent, OH 44240
Office: (330) 678-1601
Fax: (330) 678-4526
www.ashaweb.org

Gay, Lesbian and Straight Education Network (GLSEN)
121 West 27th St., Suite 804
New York, NY 10001

Office: (212) 727-0135
Fax: (212) 727-0254
www.glsen.org

National Education Association (NEA)
Human & Civil Rights
1201 16th Street, NW
Washington, DC 20036-3290
Office: (202) 822-7700
Fax: (202) 822-7578
www.nea.org

National School Boards Association (NSBA)
1680 Duke Street
Alexandria, VA 22314
Office: (703) 838-6756
Fax: (703) 548-5616
www.nsba.org/schoolhealth

Faith Organizations

The Interfaith Alliance Foundation
1012 14th St. NW, Suite 700
Washington, DC 20005
Office: (202) 639-6370
Fax: (202) 639-6375
www.tialliance.org

New Ways Ministry (Catholic)
4012 29th Street
Mt. Ranier, MD 20712
Office: (301) 277-5674
Fax: (301) 864-6948

Other National Organizations Serving Gay, Lesbian & Bisexual Youth

Lambda Legal Defense and Education Fund (LLDEF)
120 Wall Street, Suite 1500
New York, NY 10005
Office: (212) 809-8585
Fax: (212) 809-0055
www.lambdalegal.org

National Youth Advocacy Coalition (NYAC)
1638 R Street NW, Suite 300
Washington, DC 20009
Office: (202) 319-7596
Fax: (202) 319-7365
www.nyacyouth.org

Parents, Families, and Friends of Lesbians and Gays (PFLAG)
1101 14th St. NW, Suite 1030
Washington, DC 20005
Office: (202) 638-4200

Fax: (202) 638-0243
www.pflag.org

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What is the "Just the Facts Coalition" and how did this document come about?

In November of 1998, a conservative political organization sponsored a conference near Columbus, Ohio with the goal of encouraging the promotion of "reparative therapy" programs in public schools. Staff from the Gay, Lesbian and Straight Education Network (GLSEN) attended this event and were disturbed at what they learned. In December of 1998, Kate Frankfurt, GLSEN's Director of Advocacy, shared the content of this initiative and the November conference with a number of national education, health and mental health organizations at a meeting in Washington, D.C. These organizations, recognizing the disturbing implications of this initiative and the potential threat it posed to the health and well-being of lesbian, gay, and bisexual students, began meeting regularly to develop a resource to aid school officials in sorting through the information and misinformation on sexual orientation development and on "reparative therapy."

This publication is the result of the work of the groups who participated in those meetings during the spring and summer of 1999. Among the groups who have participated in this work and have officially endorsed this publication are:

- American Academy of Pediatrics
- American Counseling Association
- American Association of School Administrators
- American Federation of Teachers
- American Psychological Association
- American School Health Association
- Interfaith Alliance Foundation
- National Association of School Psychologists
- National Association of Social Workers
- National Education Association

The printing and distribution of this publication has been supported by the National Education Association, Michael Dively, the American Psychological Association, the American Federation of Teachers, the National Association of School Psychologists, and the National Association of Social Workers.

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American Psychological Association
Public Interest Directorate
750 First Street, NE
Washington, DC 20002

Public Interest Directorate
750 First Street, NE • Washington, DC • 20002-4242
Phone: 202-336-6050 • TDD/TTY: 202-336-6123
Fax: 202-336-6040 • Email

POLICY STATEMENT

GAY, LESBIAN, AND BISEXUAL PARENTS

Approved by Council June, 1999

The basis on which all decisions relating to custody and parental rights should rest on the best interest of the child. Lesbian, gay, and bisexual individuals historically have faced more rigorous scrutiny than heterosexuals regarding their rights to be or become parents.

There is no evidence to suggest or support that parents with a gay, lesbian, or bisexual orientation are per se different from or deficient in parenting skills, child-centered concerns and parent-child attachments, when compared to parents with a heterosexual orientation. It has long been established that a homosexual orientation is not related to psychopathology, and there is no basis on which to assume that a parental homosexual orientation will increase likelihood of or induce a homosexual orientation in the child.

Outcome studies of children raised by parents with a homosexual or bisexual orientation, when compared to heterosexual parents, show no greater degree of instability in the parental relationship or developmental dysfunction in children.

The AACAP opposes any discrimination based on sexual orientation against individuals in regard to their rights as custodial or adoptive parents as adopted by Council.

NOTIFICATION OF RESULTS

Counseling Today

In accordance with Sections N.5, Q.2, and Q.3 of the ACA Code of Ethics and Standards of Practice (and related documents) as approved by ACA Governing Council, 1995, please be advised of the following **permanent expulsion of membership** from the American Counseling Association effective immediately.

Mr. Richard Cohen, MA
Bowie, MD 20718

Mr. Cohen was found in violation of the following code sections A.1.a; A.1.b.; A.5.a.; A.6.a.; C.3.b.; C.3.f., and has elected not to appeal the decision taken by the ACA Ethics Committee within allotted timelines.

This information should be placed in the next issue of *Counseling Today*. If you have any questions, please feel free to contact Mr. Larry Freeman, ACA Ethics Committee Staff Liaison.

Sincerely,

Mike Hubert, M.Ed.
Senior Co-Chair, ACA Ethics Committee 2002-03

Cc: ACA Staff Liaison
ACA Ethics Committee Junior Co-Chair