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1. The American Psychiatric Association Position Statement In Support of Legal Recognition of Same-Sex Civil Marriage

- Reviewed and approved by the Joint Reference Committee 4-4-2005 and forwarded by the JRC for consideration to the Assembly. Assembly approved 5-23-2005

Available at: http://www.psych.org/public_info/libr_publ/resource.cfm:1-3.

Intent: The American Psychiatric Association (APA) should expand its current Position Statement on Same Sex Civil Unions and support legal recognition of same-sex civil marriage.

Problem: In 2000 following the creation of Vermont’s same-sex “civil unions” law, the APA passed a Position Statement in support of Same Sex Unions. In subsequent years, the issue of legal recognition of same-sex relationships has become an increasingly debated social issue. On the one hand, Canada has already legalized same-sex civil marriage in seven of ten provinces, as has Massachusetts, and two European countries. Several other countries in Europe and around the world give legal recognition to same sex unions or offer same-sex partner benefits. Legal actions challenging restrictions on same-sex marriage are occurring throughout the United States: courts in New York, California, and Washington State have ruled that heterosexual-only marriage is unconstitutional.

On the other hand, seventeen US states now have state constitutional amendments banning same sex marriage. Other legislatures are also wrestling with this issue, and some of the legislation actually prohibits any recognition of same-sex relationships or domestic partner benefits. Some court cases support this restrictive legislation and non-recognition of gay and lesbian couples and their families.

The APA has recognized the importance of stable, same-sex relationships for the mental health of gay and lesbian people, families and the community through its 2000 Position Statement on Same Sex Civil Unions and its 2002 Position Statement on Adoption and Co-Parenting of Children by Same Sex Couples. The BOT approved a stronger APA Position Statement on Same Sex Civil Unions in December 2004. At the same time, an updated APA Resource Document on Same Sex Civil Marriage was accepted by the BOT in December 2004.

In the current debate, those in favor of legal recognition of same-sex civil marriage frame it also as a civil rights issue—the denial of civil marriage to same-sex couples denies them and their families over a thousand legal benefits to which heterosexual couples and their families are currently entitled. This was highlighted in the ruling of the Massachusetts Supreme Court in upholding same-sex civil marriage, pointing out that these legal benefits and protections were not supported by same-sex civil unions, such as in Vermont. Since 1973, APA has issued numerous position statements supporting full civil rights for gay and lesbian individuals based on the values of non-discrimination and equal protection under the law.

A legally recognized marriage offers 1,049 Federal benefits and responsibilities, not including hundreds more offered by every state. Same sex civil unions, regardless of which state offers them, are more limited in the range of benefits they provide couples. Some benefits of the legal recognition of same-sex civil marriage that are denied to same-sex couples in a civil union include: Social Security and Veteran death benefits; the ability to file joint Federal income tax returns; an exemption from inheritance, gift and property transfer taxes; an exemption from taxation of

retirement savings in case of spousal death; the ability to sponsor family members for immigration; automatic rights to a spouse's estate, regardless of whether a will exists; employer-sanctioned sick leave, bereavement leave, health insurance, disability benefits and pension; the benefit of spouses being able to give an unlimited amount of gifts to each other without being taxed; being entitled to joint child custody and visitation upon divorce (and bear an obligation to pay child support).

In July 2004, the American Psychological Association adopted a resolution supporting the legalization of same-sex civil marriages stating that denying same-sex couples legal access to civil marriage is unfair and discriminatory and can adversely affect the psychological, physical, social and economic well-being of gay and lesbian individuals based on the research literature.

Finally, APA has also been asked by other professional organizations to take a position in the courts and in other public arenas on same-sex civil marriage. In response, APA's Committee on Judicial Action has recommended to the Board of Trustees that the APA sign on to two *amici curiae* briefs authored by the American Psychological Association in lawsuits challenging existing marriage laws in New Jersey and Oregon [See Appendix]. In November 2004, the Massachusetts Psychiatric Society issued a Position Paper in support of same-sex civil marriage.

Because of the above factors, there is a timely need for a statement from APA on this issue.

Therefore, it is proposed that APA approve the following Position Statement in Support of Legal Recognition of Same-Sex Civil Marriage:

Position Statement in Support of Legal Recognition of Same-Sex Civil Marriage

As physicians who frequently evaluate the impact of social and family relationships on child development, and the ability of adults and children to cope with stress and mental illness, psychiatrists note the invariably positive influence of a stable, adult partnership on the health of all family members. Sustained and committed marital and family relationships are cornerstones of our social support network as we face life's challenges, including illness and loss. There is ample evidence that long-term spousal and family support enhances physical and mental health at all stages of development.

This position statement is about the legal recognition of same-sex civil marriage, not religious marriage, and it does not pertain to any organized religion's view of same-sex marriage.

Heterosexual relationships have a legal framework for their existence through civil marriage, which undoubtedly provides a stabilizing force. In the United States, with the exception of Massachusetts, same-sex couples are currently denied the important legal benefits, rights and responsibilities of civil marriage. Same-sex couples therefore experience several kinds of state-sanctioned discrimination that can adversely affect the stability of their relationships and their mental health.

The children of unmarried gay and lesbian parents do not have the same protection that civil marriage affords the children of heterosexual couples. Adoptive and divorced lesbian and gay parents face additional obstacles. An adoptive parent who is lesbian or gay is often prejudicially presumed as unfit in many U.S. jurisdictions. Furthermore, when unmarried couples do adopt, usually one parent is granted legal rights, while the other parent may have no legal standing. These obstacles occur even though research has shown that the children raised by lesbian and gay men are as well adjusted as those reared within heterosexual relationships.

As the population ages, the denial of legal recognition of civil marriage has consequences for increasing numbers of older adults in same-sex relationships who face age-related health and financial concerns. Excluding these adults from civil marriage protections of survivorship and inheritance rights, financial benefits, and legal recognition as a couple in health care settings increases the psychological burden associated with aging.

The American Psychiatric Association has historically supported equity, parity, and non-discrimination in matters that have an impact on mental health. APA has also supported same-sex civil unions and the right of same-sex couples to adopt and co-parent children. This is because APA has a longstanding interest in civil rights and legal issues that affect mental health as well as a code of ethics that supports and respects human dignity. Educating the public about lesbian and gay relationships and supporting efforts to establish legal recognition of same-sex civil marriage is consistent with the Association's advocacy for minority groups.

Civil marriage is associated with a unique set of benefits that provide legal and economic protections to adults in committed relationships and to their children. Equal access to the institution of civil marriage is consistent with the APA's opposition to discrimination based on sexual orientation.

Therefore be it resolved that:

"The American Psychiatric Association supports the legal recognition of same-sex civil marriage with all rights, benefits, and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities."

Supporting Documents:

American Psychiatric Association (1973), Position statement on homosexuality and civil rights. *American J. Psychiatry*, 1974, 131:497. www.psych.org/edu/other_res/lib_archives/archives/730010.pdf

American Psychiatric Association (1990), Position statement on homosexuality and the armed services. www.psych.org/edu/other_res/lib_archives/archives/900013.pdf

American Psychiatric Association (1991), Position statement: Homosexuality and the Immigration and Naturalization Service. *American J. Psychiatry*, 148:1625.

American Psychiatric Association Committee on Gay, Lesbian, and Bisexual Issues (1993), Position statement on homosexuality. *American J. Psychiatry*, 150:686. www.psych.org/edu/other_res/lib_archives/archives/730010.pdf

Resource Document on Controversies in Child Custody: Gay and Lesbian Parenting; Transracial Adoptions; Joint v. Sole Custody and Custody Gender Issues: Approved by Board of Trustees, December 1997.

Resource Document on Same Sex Marriage: Approved by the Board of Trustees, December 1998.

American Psychiatric Association (1998), Position statement on psychiatric treatment and sexual orientation. *American J. Psychiatry*, 1999; 156:1131. www.psych.org/edu/other_res/lib_archives/archives/980020.pdf

American Psychiatric Association (2000), Commission on Psychotherapy by Psychiatrists (COPP): Position statement on therapies focused on attempts to change sexual orientation (Reparative or conversion therapies). *American J. Psychiatry*, 157:1719-1721. www.psych.org/edu/other_res/lib_archives/archives/200001.pdf

American Psychiatric Association (2000), Position statement on same sex civil unions. December 2000

American Psychiatric Association (2002), Position Statement on Adoption and Co-Parenting of Children by Same Sex Couples. November 2002.

Brief for Amici Curiae in the case of *Lawrence and Garner v. Texas* (signed by American Psychiatric Association), January 2003.

www.psych.org/edu/other_res/lib_archives/archives/amicus/02-102.pdf

American Psychological Association (2004), Resolution on Sexual Orientation and Marriage. <http://www.apa.org/pi/lgbcpolicy/marriage.pdf>

Amended APA Resource Document on Same Sex Marriage; Approved by the Board of Trustees, December 2004.

American Psychiatric Association: Position statement on same sex civil unions (revised); Approved by Board of Trustees, December 2004.

Position paper of the Massachusetts Psychiatric Society on Gay Marriage, November 2004.

2. The American Medical Association policy statements about adoption, civil rights, and sexual orientation.

H-60.940 Partner Co-Adoption_Our AMA will support legislative and other efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (Res. 204, A-04)

H-65.979 Sexual Orientation as an Exclusionary Criterion for Youth Organization._Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation. (Res. 414, A-01)

H-65.983 Nondiscrimination Policy._The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03)

H-65.990 Civil Rights Restoration._The AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03)

3. The American Psychological Association: Sexual Orientation and Marriage

Adopted by the APA Council of Representatives, July 2004

Research Summary

Minority Stress in Lesbian, Gay, and Bisexual Individuals

Psychological and psychiatric experts have agreed since 1975 that homosexuality is neither a form of mental illness nor a symptom of mental illness (Conger, 1975). Nonetheless, there is growing recognition that social prejudice, discrimination, and violence against lesbians, gay men, and bisexuals take a cumulative toll on the well-being of these individuals. Researchers (e.g., DiPlacido, 1998; Meyer, 2003) use the term "minority stress" to refer to the negative effects associated with the adverse social conditions experienced by individuals who belong to a stigmatized social group (e.g., the elderly, members of racial and ethnic minority groups, the physically disabled, women, the poor or those on welfare, or individuals who are gay, lesbian, or bisexual).

A recent meta-analysis of population-based epidemiological studies showed that lesbian, gay, and bisexual populations have higher rates of stress-related psychiatric disorders (such as those related to anxiety, mood, and substance use) than do heterosexual populations (Meyer, 2003). These differences are not large but are relatively consistent across studies (e.g., Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Mays & Cochran, 2001). Meyer also provided evidence that within lesbian, gay, and bisexual populations, those who more frequently felt stigmatized or discriminated against because of their sexual orientation, who had to conceal their homosexuality, or who were prevented from affiliating with other lesbian, gay, or bisexual individuals tended to report more frequent mental health concerns. Research also shows that compared to heterosexual individuals and couples, gay and lesbian individuals and couples experience economic disadvantages (e.g., Badgett, 2001). Finally, the violence associated with hate crimes puts lesbians, gay men and bisexual individuals at risk for physical harm to themselves, their families, and their property (D'Augelli, 1998; Herek, Gillis, & Cogan, 1999). Taken together, the evidence clearly supports the position that the social stigma, prejudice, discrimination, and violence associated with not having a heterosexual sexual orientation and the hostile and stressful social environments created thereby adversely affect the psychological, physical, social, and economic well-being of lesbian, gay, and bisexual individuals.

Same-Sex Couples

Research indicates that many gay men and lesbians want and have committed relationships. For example, survey data indicate that between 40% and 60% of gay men and between 45% and 80% of lesbians are currently involved in a romantic relationship (e.g., Bradford, Ryan, & Rothblum, 1994; Falkner & Garber, 2002; Morris, Balsam, & Rothblum, 2002). Further, data from the 2000 United States Census (United States Census Bureau, 2000) indicate that of the 5.5 million couples who were living together but not married, about 1 in 9 (594,391) had partners of the same sex. Although the Census data are almost certainly an underestimate of the actual number of cohabiting same-sex couples, they indicated that a male householder and a male partner headed 301,026 households and that a female householder and a female partner headed 293,365 households.¹ Despite persuasive evidence that gay men and lesbians have committed relationships, three concerns about same-sex couples are often raised. A first concern is that the relationships of gay men and lesbians are dysfunctional and unhappy. To the contrary, studies that have compared partners from same-sex couples to partners from heterosexual couples on standardized measures of

relationship quality (such as satisfaction and commitment) have found partners from same-sex and heterosexual couples to be equivalent to each other (see reviews by Peplau & Beals, 2004; Peplau & Spalding, 2000). (The same-sex couples identified in the U.S. Census may include couples in which one or both partners are bisexually identified, rather than gay or lesbian identified.)

A second concern is that the relationships of gay men and lesbians are unstable. However, research indicates that, despite the somewhat hostile social climate within which same-sex relationships develop, many lesbians and gay men have formed durable relationships. For example, survey data indicate that between 18% and 28% of gay couples and between 8% and 21 % of lesbian couples have lived together 10 or more years (e.g., Blumstein & Schwartz, 1983; Bryant & Demian, 1994; Falkner & Garber, 2002; Kurdek, 2003). Researchers (e.g., Kurdek, in press) have also speculated that the stability of same-sex couples would be enhanced if partners from same-sex couples enjoyed the same levels of social support and public recognition of their relationships as partners from heterosexual couples do.

A third concern is that the processes that affect the well-being and permanence of the relationships of lesbian and gay persons are different from those that affect the relationships of heterosexual persons. In fact, research has found that the factors that predict relationship satisfaction, relationship commitment, and relationship stability are remarkably similar for both same-sex cohabiting couples and heterosexual married couples (Kurdek, 2001, in press).

Resolution

WHEREAS APA has a long-established policy to deplore "all public and private discrimination against gay men and lesbians" and urges "the repeal of all discriminatory legislation against lesbians and gay men" (Conger, 1975, p. 633);

WHEREAS the APA adopted the Resolution on Legal Benefits for Same-Sex Couples in 1998 (Levant, 1998, pp. 665-666.

WHEREAS Discrimination and prejudice based on sexual orientation detrimentally affects psychological, physical, social, and economic well-being (Badgett, 2001; Cochran, Sullivan, & Mays, 2003; Herek, Gillis, & Cogan, 1999; Meyer; 2003);

WHEREAS "Anthropological research on households, kinship relationships, and families, across cultures and through time, provide[s] no support whatsoever for the view that either civilization or viable social orders depend upon marriage as an exclusively heterosexual institution" (American Anthropological Association, 2004);

WHEREAS Psychological research on relationships and couples provides no evidence to justify discrimination against same-sex couples (Kurdek, 2001, in press; Peplau & Beals, 2004; Peplau & Spalding, 2000);

WHEREAS The institution of civil marriage confers a social status² and important legal benefits, rights, and privileges³;

WHEREAS The United States General Accounting Office (2004) has identified over 1,000 federal statutory provisions in which marital status is a factor in determining or receiving benefits, rights, and privileges, for example, those concerning taxation, federal loans, and dependent and survivor benefits (e.g., Social Security, military, and veterans);

WHEREAS There are numerous state, local, and private sector laws and other provisions in which marital status is a factor in determining or receiving benefits, rights, and privileges, for example, those concerning taxation, health insurance, health care decision-making, property rights, pension and retirement benefits, and inheritance⁴;

WHEREAS Same-sex couples are denied equal access to civil marriage⁵;

WHEREAS Same-sex couples who enter into a civil union are denied equal access to all the benefits, rights, and privileges provided by federal law to married couples (United States General Accounting Office, 2004)⁶;

WHEREAS The benefits, rights, and privileges associated with domestic partnerships are not universally available⁷, are not equal to those associated with marriage⁸, and are rarely portable⁹;

WHEREAS people who also experience discrimination based on age, race, ethnicity, disability, gender and gender identity, religion, and socioeconomic status may especially benefit from access to marriage for same-sex couples (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients, 2000);

THEREFORE BE IT RESOLVED That the APA believes that it is unfair and discriminatory to deny same-sex couples legal access to civil marriage and to all its attendant benefits, rights, and privileges;

THEREFORE BE IT FURTHER RESOLVED That APA shall take a leadership role in opposing all discrimination in legal benefits, rights, and privileges against same-sex couples;

THEREFORE BE IT FURTHER RESOLVED That APA encourages psychologists to act to eliminate all discrimination against same-sex couples in their practice, research, education and training ("Ethical Principles," 2002, p. 1063);

THEREFORE BE IT FURTHER RESOLVED That the APA shall provide scientific and educational resources that inform public discussion and public policy development regarding sexual orientation and marriage and that assist its members, divisions, and affiliated state, provincial, and territorial psychological associations.

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4. American Psychoanalytic Association (APsaA) Marriage Resolution

www.apsa.org

March 3, 2004. For more information, contact Dottie Jeffries, 212-752-0450, ext. 29; djeffries@apsa.org. Available at: <http://www.psych.org/pnews/98-02-06/marriage.html>.

STATEMENT: Psychoanalysts Reaffirm Marriage Resolution

New York, NY- In response to President Bush's call for a constitutional amendment to ban gay marriage, the **American Psychoanalytic Association** reaffirms its 1997 Marriage Resolution:

"Because marriage is a basic human right and an individual personal choice, RESOLVED, the State should not interfere with same-gender couples who choose to marry and share fully and equally in the rights, responsibilities, and commitment of civil marriage."

Following discussion, the Marriage Resolution was endorsed by an overwhelming majority vote of APsaA's Executive Council on December 18, 1997, with only one negative vote and one abstention.

5. National Association of Social Workers: Same-Sex Marriage Position Statement

Affirmed by the Board of Directors on June 28, 2004

The National Board of Directors of the National Association of Social Workers (NASW) reaffirms the Association's support for same-sex marriages, and strongly opposes any attempt to pass federal legislation or amend the United States Constitution to discriminate against same-sex couples or prohibit governmental recognition of these relationships.

Specifically, the Board of Directors supports working toward implementation of domestic partnership and **marriage legislation** at local, state, and national levels that includes lesbians, gays, bisexuals, and transgender people. The Board also endorses the development and dissemination of model anti-discrimination, domestic partnership, and marriage legislation, which may be used in municipal, state, and national legislatures.

This statement arises from the following fundamental principles, articulated in the NASW Code of Ethics, as well as from positions adopted in various policy statements by numerous delegate assemblies (the policy setting body of the National Association of Social Workers):

The *NASW Code of Ethics* states: "Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical

disability."

"Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability."

NASW encourages the adoption of laws that recognize inheritance, insurance, same-sex marriage, child custody, property, and other rights in lesbian, gay, bisexual, and transgender relationships. The Association firmly believes that all federal protections and responsibilities available to legally married people in the United States should be available to people who enter same sex unions (including domestic partnerships, civil unions, and same sex marriages).

Furthermore, NASW promotes equal protection under the law, and strongly supports the full implementation of existing civil rights legislation and its application to women; to people of color; and to gays, lesbians, bisexuals, and transgender people. And, because we believe that everyone is entitled to equal opportunity — regardless of age, disability, gender, language, race, religion, or sexual orientation — NASW endorses local, state, and federal policies and programs that give all people equal access to the resources, services, and opportunities that they require.

It is imperative that social workers advocate for the rights of vulnerable people. It is equally critical, NASW believes, that social workers condemn policies, practices, and attitudes of bigotry, intolerance, and hate that put any person's human rights in jeopardy, including — but not limited to — violation of human rights based on sexual orientation.

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National Association of Social Workers SAME-SEX MARRIAGE – FACT SHEET

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers respect the inherent dignity and worth of the person and treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people. Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against person, group, or class on the basis of race, ethnicity,

national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

—There are more than 1,000 federal protections and responsibilities denied to gay, lesbian, bisexual and transgender families because they cannot legally marry in this country. Rights that married people take for granted are denied to committed same-sex couples because the law does not recognize their relationships. Without the legal right to marry for example:

- Same-sex couples do not have rights like family health coverage, child custody and medical and bereavement leave,
- Same-sex couples cannot file joint tax returns and enjoy income and estate tax benefits,
- LGBT persons cannot assume pension or Social Security benefits in the event of the death of a same-sex partner,
- LGBT persons do not have the automatic ability to make medical decisions for an incapacitated spouse,
- LGBT persons cannot petition for their same-sex partner to immigrate,
- LGBT persons are not entitled to leave of absence (up to 12 weeks) from work to care for a seriously ill partner or parent of a partner,
- Parenting responsibilities of children brought into LGBT families through birth, adoption, surrogacy or other means can be questioned or challenged through legal means, and
- LGBT persons do not have the ability to purchase continued health coverage for a same-sex partner after the loss of a job.

6. American Medical Women's Association: Position Paper on Marriage

Based on all available literature, it has been clearly shown that there is no psychiatric or physiological pathology associated with a gay, lesbian, or bisexual orientation. However gay, lesbian, and bisexual people's relationships are proscribed by the legal code of many states, with legal marriage denied them in every state of the United States, decreasing the stability of gay or lesbian committed relationships. This country also prohibits its gay, lesbian, and bisexual citizens from serving openly in the armed forces with no regard to their service record. This legal discrimination reflects an unfortunate and pervasive hatred of gay, lesbian and bisexual people causing psychological harms, violence, and legal and religious prohibitions, all with medical consequences.

These homophobic societal and family attitudes affect those children who recognize a gay, lesbian or bisexual identity within themselves, conferring on them a tenfold risk of suicide in comparison to heterosexual youth. Homophobic attitudes of society and the family further perpetuate low self-esteem in the lesbian, gay or bisexual adult resulting in higher rates of substance abuse, psychological distress, and relational dysfunction. Research indicates that health care practitioners also have homophobic attitudes, which impact negatively on quality patient care, adding to the distress of the patient, and creating alienation from the medical system, with subsequent loss of care.

There is only minimal research on lesbian health issues, with survey data suggesting that lesbians may have a higher body fat index, lower parity, fewer and less frequent visits to the physician for

screening, and higher rates of smoking and alcohol use and abuse, putting lesbians theoretically at higher rates of breast, colon, ovarian, endometrial and lung cancer as well as heart disease. We believe that discrimination against any humans on the basis of their gender, ethnicity, race, nationality, religion, age, physical ability, or sexual orientation should not be tolerated as such discrimination has serious health consequences. We believe that, as physicians, our attitudes have an impact on those of society, and should set a clear example of respect for diversity.

The American Medical Women's Association thus stands unified in a broad policy of nondiscrimination against lesbian, bisexual and gay individuals, urging the following:

- **National legislation to end discrimination by sexual orientation in housing, employment, marriage and tax laws, child custody and adoption laws, to redefine family to encompass the full diversity of all family structures and to ratify marriage for gay, lesbian, and bisexual people.**
- Vigorous condemnation of anti-gay prejudice and violence by leaders in our government, religion, education, business and the media, with swift prosecution of those who commit hate crimes based on sexual orientation.
- Creation and implementation of educational programs about lesbian, gay and bisexual people and their families in the schools, religious institutions and the wider community to teach respect for all humans.
- Initiation of and National Institute of Health support of prospective research on lesbian health issues, with stratification of existing longitudinal studies by sexual orientation so that a demographic picture can be generated and appropriate targeting for screening tests initiated.
- Recognition by all healthcare providers that homophobia is a health hazard to all individuals, and compromises the delivery of our highest standard of medical care.

Adopted without opposition by the House of Delegates, November 1993

7. American Academy Of Pediatrics: Coparent or Second-Parent Adoption by Same-Sex Parents

Committee on Psychosocial Aspects of Child and Family Health

Children who are born to or adopted by 1 member of a same-sex couple deserve the security of 2 legally recognized parents. Therefore, the American Academy of Pediatrics supports legislative and legal efforts to provide the possibility of adoption of the child by the second parent or coparent in these families.

Children deserve to know that their relationships with both of their parents are stable and legally recognized. This applies to all children, whether their parents are of the same or opposite sex. The American Academy of Pediatrics recognizes that a considerable body of professional literature provides evidence that children with parents who are homosexual can have the same advantages and the same expectations for health, adjustment, and development as can children whose parents are heterosexual.^{1,2} When 2 adults participate in parenting a child, they and the child deserve the serenity that comes with legal recognition.

Children born or adopted into families headed by partners who are of the same sex usually have only 1 biologic or adoptive legal parent. The other partner in a parental role is called the "coparent" or "second parent." Because these families and children need the permanence and security that are provided by having 2 fully sanctioned and legally defined parents, the Academy supports the legal adoption of children by coparents or second parents. Denying legal parent status through adoption to coparents or second parents prevents these children from enjoying the psychological and legal security that comes from having 2 willing, capable, and loving parents.

Several states have considered or enacted legislation sanctioning second-parent adoption by partners of the same sex. In addition, legislative initiatives assuring legal status equivalent to marriage for gay and lesbian partners, such as the law approving civil unions in Vermont, can also attend to providing security and permanence for the children of those partnerships.

Many states have not yet considered legislative actions to ensure the security of children whose parents are gay or lesbian. Rather, adoption has been decided by probate or family courts on a case-by-case basis. Case precedent is limited. It is important that a broad ethical mandate exist nationally that will guide the courts in providing necessary protection for children through coparent adoption.

Coparent or second-parent adoption protects the child's right to maintain continuing relationships with both parents. The legal sanction provided by coparent adoption accomplishes the following:

- Guarantees that the second parent's custody rights and responsibilities will be protected if the first parent were to die or become incapacitated. Moreover, second-parent adoption protects the child's legal right of relationships with both parents. In the absence of coparent adoption, members of the family of the legal parent, should he or she become incapacitated, might successfully challenge the surviving coparent's rights to continue to parent the child, thus causing the child to lose both parents.

- Protects the second parent’s rights to custody and visitation if the couple separates. Likewise, the **child’s right to maintain relationships with both parents after separation**, viewed as important to a positive outcome in separation or divorce of heterosexual parents, would be protected for families with gay or lesbian parents.
- **Establishes the requirement for child support from both parents** in the event of the parents’ separation.
- Ensures the child’s eligibility for health benefits from both parents.
- Provides legal grounds for **either parent to provide consent for medical care** and to make education, health care, and other important decisions on behalf of the child.
- **Creates the basis for financial security for children in the event of the death of either parent** by ensuring eligibility to all appropriate entitlements, such as Social Security survivor’s benefits.
- On the basis of the acknowledged desirability that children have and maintain a continuing relationship with 2 loving and supportive parents, the Academy recommends that pediatricians do the following:
 - Be familiar with professional literature regarding gay and lesbian parents and their children.
 - Support the right of every child and family to the financial, psychologic, and legal security that results from having legally recognized parents who are committed to each other and to the welfare of their children.
 - **Advocate for initiatives that establish permanency through coparent or second-parent adoption for children of same-sex partners through the judicial system, legislation, and community education.**

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8. American Psychiatric Association: Reparative therapy, military service, children's issues.

February 2000

In December 1973, the American Psychiatric Association's Board of Trustees deleted homosexuality from its official nomenclature of mental disorders, 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. For a mental condition to be considered a psychiatric disorder, it must constitute dysfunction within an individual, cause present distress (e.g., a painful symptom), disability (e.g., impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. A homosexual or bisexual individual may experience conflict with a homophobic society; however, such conflict is not a symptom of dysfunction in the individual. The APA Board recognized that a significant portion of homosexual and bisexual people were clearly satisfied with their sexual orientation and showed no signs of psychopathology. It was also found that they were able to function effectively in society, and that those who sought treatment most often did so for reasons other than sexual orientation.

When the DSM-III was published in 1980 homosexuality was not included although "ego dystonic homosexuality" was recognized as a category for people "whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation." In the 1987 DSM-III revision, "ego dystonic homosexuality" was deleted as a separate diagnostic category in recognition that "In the United States, almost all people who are homosexual first go through a phase in which their homosexuality is ego dystonic" (DSM-III-R).

"Reparative Therapy"

"Reparative therapy," also known as conversion therapy, is a term that is used to describe treatment attempts to change a person from a homosexual or bisexual orientation to a heterosexual orientation. There is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation. It is not described in the scientific literature, nor is it mentioned in the APA's Task Force Report, *Treatments of Psychiatric Disorders* (1989).

Sexual orientation, like gender identity, appears to be established early in life. There is no evidence that altering sexual orientation is an appropriate goal of psychiatric treatment. There are single case reports of changes or increased flexibility in the capacity to respond heterosexually—or homosexually—during psychotherapy, but no specific treatment to permanently realize such changes has been documented. Clinical experience suggests that attempts to change sexual orientation may occasionally result in behavioral changes for some motivated individuals for limited periods of time, but that such changes often are accompanied by depression, anxiety, and other symptoms.

Homosexuals and bisexuals—like others—are raised in a homophobic society and often experience internalized homophobia. Some may seek conversion to heterosexuality on that

account. Clinical experience suggests that relief of homophobia allows for better psychological functioning. Those who have integrated their sexual orientation into a positive sense of themselves function at a healthier psychological level than those who have not. In December 1998, the APA Board adopted a position statement on psychiatric treatment and sexual orientation which said in part: "...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 Psychiatric Treatment and Sexual Orientation on page 3.) Several other major professional organizations including the American Psychological Association, the National Association of Social Workers and the American Academy of Pediatrics also have made statements against "reparative therapy" because of concerns for the harm caused to patients.

Sensitive and Affirmative Therapy

Homosexual and bisexual men and women have experienced increased social acceptance and recognition over the last several decades. Bias, prejudice, and stigmatization of these individuals—and of homosexuality itself—however, continue. These factors can contribute to shame and poor self-esteem, and be a component in the mental health presentation of some homosexuals and bisexuals seeking psychotherapy or psychopharmacology. Therapy that is "gay sensitive"—that is, therapy provided by a therapist who is well informed about homosexuality and the issues facing homosexual and bisexual people that result from social homophobia—is most helpful for those individuals. So, too, is therapy that is "gay affirmative"—that is, therapy provided by a therapist who is positive and supportive about accepting an individual's homosexual or bisexual orientation.

Therapy that is "gay sensitive"—that is, therapy provided by a therapist who is well informed about homosexuality and the issues facing homosexual and bisexual people that result from social homophobia—is most helpful for those individuals. So, too, is therapy that is "gay affirmative"—that is, therapy provided by a therapist who is positive and supportive about accepting an individual's homosexual or bisexual orientation.

APA Position Statements on Homosexuality

Homosexuality and Civil Rights—Whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, therefore, be it resolved that the American Psychiatric Association deplors all public and private discrimination against homosexuals in such areas as employment, housing, public accommodation, and licensing, and declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon homosexuals greater than that imposed on any other persons. Further, the American Psychiatric Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer homosexual citizens the same protections now guaranteed to others on the basis of race, creed, color, etc. Further, the American Psychiatric Association supports and urges the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private. (The American Psychiatric Association is, of course, aware that many other persons in addition to homosexuals are irrationally denied their civil rights on the basis of pejorative connotations derived from diagnostic or descriptive terminology used in psychiatry and deplors all such discrimination. This resolution singles out discrimination against homosexuals only because of the

pervasive discriminatory acts directed against this group and the arbitrary laws directed against homosexual behavior.) (November 1973)

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 employment discrimination are potentially severe occupational stressors. Complaints of sexual harassment and 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)

Homosexuality and the 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)

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 U.S. 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, licensing, and immigration and naturalization decisions. The U.S. Immigration and Naturalization Service (INS), 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 INS. The APA believes that neither physical illness nor mental illness nor sexual orientation per se should be a basis for immigration or naturalization exclusion. (1991)

Homosexuality—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 penalizes 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.**

(December 1992)

Bias-Related Incidents—Bias-related incidents, arising from racism, sexism, and 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 manifested in bias-related incidents, serve to frustrate the basic human need for dignity, resulting in despair and hopelessness among the victims which ultimately affect the whole nation. The APA deplors 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)

Psychiatric Treatment and 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 with the effects of societal stigmatization discussed. 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 priori assumption that the patient should change his/her homosexual orientation. (December 1998)

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9. American Academy Of Pediatrics: Child and Family Health, Adolescence, Sexuality Education for Children and Adolescents

ABSTRACT. Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults. Early, exploitative, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection and acquired immunodeficiency syndrome. This statement reviews the role of the pediatrician in providing sexuality education to children, adolescents, and their families. Pediatricians should integrate sexuality education into the confidential and longitudinal relationship they develop with children, adolescents, and families to complement the education children obtain at school and at home.

• **Gay, lesbian, and bisexual youth.** Maintain nonjudgmental attitudes and avoid a heterosexual bias in history taking to encourage adolescents to be open about their behaviors and feelings (see the AAP statement “Homosexuality and Adolescence”⁹).^{30,31} If adolescents are certain of homosexual or bisexual orientation, discuss advantages and potential risks of disclosure to family and peers, and support families in accepting children who identify themselves as gay, lesbian, or bisexual. Adolescents who are homosexual should be screened carefully for depression, risk of suicide, and adjustment related mental health problems. Similar issues are important to children unsure of their sexual orientation.

9. American Academy Of Pediatrics: Sexual Orientation And Adolescents 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.

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 actions; 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} Sorenson¹⁵ 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}

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 sero-prevalence, 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 to²⁸:

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 adolescents’ 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 “boy-friend” 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 sites³⁴
 - HIV testing with appropriate support and counseling³⁵
 - 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 non-heterosexuality to their parents. If unsure, assist the adolescent in finding a knowledgeable professional who can help.
2. Be knowledgeable about the process of disclosure.
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 1983⁴² and 1993⁴³ 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.

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10. Child Welfare League of America Position Statement on Parenting of Children by Gay, Lesbian, and Bisexual Adults

The Child Welfare League of America (CWLA) affirms that gay, lesbian, and bisexual parents are as well suited to raise children as their heterosexual counterparts.

Since 1920, CWLA and its member agencies have worked to ensure that abused, neglected, and other vulnerable children are protected from harm. CWLA strives to advance research-based best practices and sound public policy on behalf of the nine million vulnerable children served by our approximately 900 member agencies. We believe every child and youth has a value to society and we envision a future in which families, neighborhoods, communities, organizations, and governments ensure that all children and youth are provided with the resources and supports they need to grow into healthy, contributing members of society.

Among its member agencies, CWLA also values and encourages approaches to child welfare that are culturally competent and responsive to the specific needs of our society's broad and diverse population. Included in CWLA's definition of cultural competence is the ability to support children, youth, and families who are gay, lesbian, bisexual, or transgender (GLBT), as well as those individuals who may be questioning (Q) their sexual orientation or gender identity.

CWLA has operationalized its support of GLBTQ children, youth, and families by working in partnership with Lambda Legal, the nation's oldest and largest civil rights organization dedicated to supporting GLBT people, as well as people with HIV or AIDS. Together, CWLA and Lambda Legal have created an initiative entitled Fostering Transitions: CWLA/Lambda Joint Initiative to Support GLBTQ Youth and Adults Involved with the Child Welfare System. The goal of the initiative is to increase the child welfare system's capacity to meet the needs of gay, lesbian, bisexual, transgender and questioning (GLBTQ) children, youth, adults, and families. CWLA is pursuing this goal by providing education, technical assistance, resource development and dissemination, programmatic coordination, and advocacy to CWLA member agencies and the greater child welfare field.

The number of children in America currently being raised by gay, lesbian, or bisexual parents is unknown. Resistance to gay and lesbian rights continues to force many gay and lesbian people to remain silent about their sexual orientation and relationships. But several studies indicate the numbers of children with same-sex parents in America are significant. According to the 2000 U.S. Census, there are approximately 600,000 same-sex couples in the United States (Simmons & O'Connell, 2003). More than 30% of these couples have at least one child, and over half of that 30% have two or more children. **Therefore, parents of the same sex are raising at least 200,000 children--possibly more than 400,000--in America (these numbers do not include single lesbian or single gay parents).** The 2000 U.S. Census also reported that gay and lesbian families live in 99.3% of all U.S. counties (Smith & Gates, 2001). **A 1995 National Health and Social Life Survey by E.O. Lauman found that up to nine million children in America have gay or lesbian parents**

(Committee on Psychosocial Aspects of Child and Family Health, 2002).

Based on more than three decades of social science research and our 85 years of service to millions of families, CWLA believes that families with GLBTQ members deserve the same levels of support afforded other families. Any attempt to preclude or prevent gay, lesbian, and bisexual individuals or couples from parenting, based solely on their sexual orientation, is not in the best interest of children.

CWLA, therefore, affirms that gay, lesbian, and bisexual parents are as well suited to raise children as their heterosexual counterparts.

Existing Social Science Research Supporting Same-Sex Parenting

Existing research comparing gay and lesbian parents to heterosexual parents, and children of gay and lesbian parents to children of heterosexual parents, shows that common negative stereotypes are not supported (Patterson, 1995). Likewise, beliefs that gay and lesbian adults are unfit parents have no empirical foundation (American Psychological Association, 1995).

A growing body of scientific evidence demonstrates that children who grow up with one or two parents who are gay or lesbian fare as well in emotional, cognitive, social, and sexual functioning as do children whose parents are heterosexual. Evidence shows that children's optimal development is influenced more by the nature of the relationships and interactions within the family unit than by its particular structural form (Perrin, 2002).

Studies using diverse samples and methodologies in the last decade have persuasively demonstrated that there are no systematic differences between gay or lesbian and non-gay or lesbian parents in emotional health, parenting skills, and attitudes toward parenting (Stacey & Biblarz, 2001). No studies have found risks to or disadvantages for children growing up in families with one or more gay parents, compared to children growing up with heterosexual parents (Perrin, 2002). Indeed, evidence to date suggests home environments provided by gay and lesbian parents support and enable children's psychosocial growth, just as do those provided by heterosexual parents (Patterson, 1995).

Prevalent heterosexism, sexual prejudice, homophobia, and resulting stigmatization might lead to teasing, bullying, and embarrassment for children about their parent's sexual orientation or their family constellation, restricting their ability to form and maintain friendships. Nevertheless, children seem to cope well with the challenges of understanding and describing their families to peers and teachers (Perrin, 2002). CWLA concludes that problems associated with such family formations do not emanate from within the family unit, but from prejudicial forces on the outside. Children of gay, lesbian, and bisexual parents are better served when society works to eliminate harmful, prejudicial attitudes directed toward them and their families.

CWLA Standards Support Same-Sex Parenting

CWLA's policies and standards are consistent with existing research on outcomes of children raised by gay, lesbian, or bisexual parents. CWLA develops and disseminates the Standards of Excellence for Child Welfare Services as benchmarks for high-quality services that protect children and youth and strengthen families and neighborhoods.

CWLA develops and revises its Standards through a rigorous, inclusive process that challenges

child welfare agency representatives and national experts to address both persistent and emerging issues, debate current controversies and concerns, review research findings, and develop a shared vision reflecting the best current theory and practice. The Standards provide goals for the continuing improvement of services for children and families, and compare existing practice with what is considered most desirable for children and their families. The Standards are widely accepted as the foundation for sound U.S. child welfare practice, providing goals for the continuing improvement of services to children and their families.

As they pertain to GLBTQ children, youth, and families, CWLA's Standards of Excellence for Family Foster Care Services do not include requirements for adults present in the home to be legally related by blood, adoption, or legal marriage. Specifically, section 3.18 of the foster care standards establishes a policy of nondiscrimination in the selection of foster parents, stating: "The family foster care agency should not reject foster parent applicants solely due to their age, income, marital status, race, religious preference, sexual orientation, physical or disabling condition, or location of the foster home" (CWLA, 1995). CWLA also articulates a strong position on the issue of nondiscrimination of adoptive applicants. Section 4.7 of the Standards of Excellence for Adoption Services states:

All applicants should be assessed on the basis of their abilities to successfully parent a child needing family membership and not on their race, ethnicity or culture, income, age, marital status, religion, appearance, differing lifestyle, or sexual orientation. **Applicants should be accepted on the basis of an individual assessment of their capacity to understand and meet the needs of a particular available child at the point of the adoption and in the future (CWLA, 2000).**

Thus, based on a preponderance of existing research substantiating the ability of gay, lesbian, and bisexual adults to serve as competent, caring, supportive and loving parents, and consistent with the Standards of Excellence for Child Welfare Services, CWLA commits its experience, its resources, and its influence to supporting GLBTQ children, youth, adults, and families involved in America's child welfare system.

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11. Is homosexuality natural? Answers from the book Biological Exuberance: Animal Homosexuality and Natural Diversity by Bagemihl B. St. Martin's Press; 1999

- This book documents 450 species of mammals and birds engaging in repeated homosexual activity from mutual masturbation, oral sex, and mounting behavior to orgasm, among and between all ages, and by both genders.
- Such “non-reproductive” recreational sex is common, with repeated encounters and often lifelong relationships, all in presence of opposite sex.
- The information was previously suppressed, or reported as “practice for real sex.”
- The gene pool is apparently preserved when families do not overpopulate and when relatives help raise other's children.

12. National Library of Medicine: Is Transsexuality a distinct, natural status?

Antoszewski, B., J. Kruk-Jeromin, et al. (1998). "Body structure of female-to-male transsexuals." Acta Chir Plast **40**(2): 54-8.

31 female-to-male transsexuals treated in the Department of Plastic Surgery, Medical University of Lodz, were examined. Anthropometric measurements were carried out according to Martin's technique. 23 measured characteristics of the examined transsexuals were studied; they were compared with identical characteristics in males and females of the control group. **The results indicate that the somatic characteristics in transsexual women are between the values typical for man and women.**

Bosinski, H. A., I. Schroder, et al. (1997). "Anthropometrical measurements and androgen levels in males, females, and hormonally untreated female-to-male transsexuals." Arch Sex Behav **26**(2): 143-57.

To elucidate the relationship between body build, androgens, and transsexual gender identity, anthropometric measurements were assessed in 15 hormonally untreated female-to-male-transsexuals (FMT). Nineteen healthy women (CF) (X = 22 years; 2 months), and 21 healthy men (CM) (X = 23; 7) were enrolled as controls. Baseline levels of testosterone (T; ng/dl), androstenedione (A4; ng/dl), dehydroepiandrosterone sulfate (DHEAS; ng/ml), and sex-hormone binding globulin (SHBG; microgram/ml) were assessed in 12 FMT, 15 CF, and in all CM. No control was under hormonal medication (including contraceptives). Absolute measurements in FMT were in accordance with their biological sex: they showed only small differences from the CF. However, FMT differed from CF in 7 of 14 sex-dimorphic indices of masculinity/femininity in body build. Of these 14 indices, 9 did not show a difference between FMT and CM. Hence, **FMT presented a more masculine body build, particularly in fat distribution and bone proportions.** Levels of T and A4 were significantly higher in FMT than in CF (T: 54.0 +/- 13.8 vs. 41.1 +/- 12.8; A4: 244.8 +/- 73.0 vs. 190.5 +/- 49.3), while DHEAS was higher in CM (3335 +/- 951) than in CF (2333

+/- 793) and in FMT (2679 +/- 1089). Altogether, 83.3% of FMT and 33.3% of CF were above normal values for at least one measured androgen. SHBG in FMT (1.21 +/- 0.70) and CF (1.87 +/- 0.91) was higher than in CM (0.49 +/- 0.18) and tended to be higher in CF than in FMT. Unbound T (T/SHBG ratio) was higher in FMT (72.0 +/- 67.6) than in CF (26.4 +/- 15.1) and correlated positively with manly body shape. Findings are discussed in relation to etiology of transsexualism.

Docter, R. F. and J. S. Fleming (2001). "Measures of transgender behavior." Arch Sex Behav **30**(3): 255-71.

Using factor analysis, we sought to identify the components of transgenderism. Subjects were 455 transvestites and 61 male-to-female transsexuals, all biological males. A 70-item questionnaire was used, along with other structured questions concerning preferred and usual sex partners. Five factors were identified and interpreted: Transgender Identity, Role, Sexual Arousal, Androallure, and Pleasure. These factors represent the most salient dimensions of transgenderism. All five-factor Means for transvestites and transsexuals differ. An examination of overlap of group distributions for each factor showed such overlap to range from only 6% for Identity to 46% for both Androallure and Pleasure. Factor intercorrelations for the obliquely rotated factors ranged from -.37 to .27. While transvestites and transsexuals have different lifestyles, their transgender cognition and behavior seem constructed upon different combinations of the same variables. A second-order analysis of these five factors yielded two factors: Sexual Arousal loaded highest on the first factor (.91), and for the second the highest loading variable was Androallure (.57). Each of these highlights the primary importance of sexual arousal in transgender cognition and behavior. Studying possible age effects, we found that the younger versus older transvestite groups had significantly different scale Means for Androallure and Pleasure; there were no age differences between older and younger transsexuals on any of the five scales. Six percent of transvestites reported a male as their usual sex partner; 25% of the transsexuals reported a female as their usual sex partner. For each group, one-third indicated their usual sex practice was without any partner, while only 5% said they preferred this practice. We propose that the five variables identified offer a comprehensive approach to the description of individual differences in transgender experience and expression.

Herman-Jeglinska, A., A. Grabowska, et al. (2002). "Masculinity, femininity, and transsexualism." Arch Sex Behav **31**(6): 527-34.

This study examined the relationship between sex role and gender identity in a Polish transsexual population where, unlike in Western countries, male-to-female (MF) transsexualism is much less common than female-to-male (FM) transsexualism. One hundred and three FM (82 primary, 21 secondary) and 29 MF (16 primary, 13 secondary) transsexuals plus 135 control males (CM) and 303 control females (CF) completed a Sex Role Inventory, which measures sex-role identification, that is, the degree to which one self-identifies with masculine and feminine characteristics. Data obtained from primary transsexuals revealed that, on a femininity scale, MF transsexuals scores exceeded not only CM but also CF. On a masculinity scale, MF transsexuals rated themselves significantly lower than CM, but at a level comparable to CF. The comparison of FM transsexuals and controls showed that, on a masculinity scale, transsexuals scored higher than CF but were not different from CM. On the femininity scale, FM transsexuals rated themselves in between the two control groups: lower than CF but slightly higher than CM. The relations

of secondary transsexuals' scores to CF and CM scores, on both masculine and feminine scales, were in the same direction as the primary transsexuals' scores. Secondary transsexuals rated themselves very similarly to their primary counterparts (the exception was a much higher score of MF-primary transsexuals than MF-secondary transsexuals on the femininity scale). Our study revealed that transsexualism does not imply a simple inversion of sex-role patterns: transsexuals differ not only from nontranssexual individuals of the same anatomical sex but also from those of the opposite sex. Moreover, MF transsexualism is not a mirror image of FM transsexualism: it constitutes a more extreme condition in the identification with feminine versus masculine personality traits. **These differences seem to be universal for different countries and regions.** The diagnostic value of our findings is discussed.

Kruijver, F. P., J. N. Zhou, et al. (2000). "Male-to-female transsexuals have female neuron numbers in a limbic nucleus." *J Clin Endocrinol Metab* **85**(5): 2034-41.

Transsexuals experience themselves as being of the opposite sex, despite having the biological characteristics of one sex. A crucial question resulting from a previous brain study in male-to-female transsexuals was whether the reported difference according to gender identity in the central part of the bed nucleus of the stria terminalis (BSTc) was based on a neuronal difference in the BSTc itself or just a reflection of a difference in vasoactive intestinal polypeptide innervation from the amygdala, which was used as a marker. Therefore, we determined in 42 subjects the number of somatostatin-expressing neurons in the BSTc in relation to sex, sexual orientation, gender identity, and past or present hormonal status. Regardless of sexual orientation, men had almost twice as many somatostatin neurons as women ($P < 0.006$). The number of neurons in the BSTc of male-to-female transsexuals was similar to that of the females ($P = 0.83$). **In contrast, the neuron number of a female-to-male transsexual was found to be in the male range.** Hormone treatment or sex hormone level variations in adulthood did not seem to have influenced BSTc neuron numbers. **The present findings of somatostatin neuronal sex differences in the BSTc and its sex reversal in the transsexual brain clearly support the paradigm that in transsexuals sexual differentiation of the brain and genitals may go into opposite directions and point to a neurobiological basis of gender identity disorder.**

Lippa, R. A. (2001). "Gender-related traits in transsexuals and nontranssexuals." *Arch Sex Behav* **30**(6): 603-14.

Thirty-eight male-to-female (M-to-F) transsexuals, 7 female-to-male (F-to-M) transsexuals, 135 nontranssexual men, and 225 nontranssexual women were assessed on the following: gender diagnosticity (GD) measures, which assessed male- vs. female-typical occupational and hobby preferences; instrumentality; expressiveness; self-ascribed masculinity; and self-ascribed femininity. M-to-F transsexuals differed strongly and significantly from nontranssexual men on GD and self-ascribed femininity (effect sizes from 1.84 to 3.40) and more weakly on instrumentality, expressiveness, and self-ascribed masculinity (effect sizes from 0.40 to 0.56). F-to-M transsexuals differed strongly and significantly from nontranssexual women on GD and on self-ascribed masculinity and femininity (effect sizes from 2.45 to 3.97), but not on instrumentality or expressiveness (effect sizes of 0.07 and 0.39). The degree to which the six assessed gender-related traits distinguished transsexual from nontranssexuals was strongly correlated with the degree to which these same traits distinguished nontranssexual men from nontranssexual women. Using comparison data from past research, M-to-F transsexuals were quite similar to gay

men on all gender-related traits except self-ascribed femininity, but F-to-M transsexuals were considerably more masculine than lesbian women on all gender-related traits except for instrumentality and expressiveness.

McFadden, D., E. G. Pasanen, et al. (1998). "Changes in otoacoustic emissions in a transsexual male during treatment with estrogen." *J Acoust Soc Am* **104**(3 Pt 1): 1555-8.

Otoacoustic emissions (OAEs) were monitored in two human males undergoing estrogen treatment prior to sex-reversal surgery. In one subject, multiple spontaneous emissions (SOAEs) appeared where none had been evident previously. One reasonable interpretation is that (in this male, at least) androgens normally produced a suppressive effect on the cochlear mechanisms responsible for SOAEs, and that the decline in androgen levels produced by the estrogenic drug led to a reduction in that suppression.

Michel, A., M. Ansseau, et al. (2002). "Comparisons of two groups of sex-change applicants based on the MMPI." *Psychol Rep* **91**(1): 233-40.

Out of 29 men asking for a sex-change, 16 reported clinical anamnesis criteria for transsexualism according to the DSM-III-R, a more restrictive diagnosis than the DSM-IV gender dysphoria diagnosis. In addition, all the subjects had taken an MMPI which, of course, did not contribute to the transsexualism diagnosis but which served to describe their personalities. The 16 subjects diagnosed as transsexual and the 13 who did not qualify for this diagnosis were compared on the basis of personality variables measured by the MMPI. Certain differences became evident. The transsexuals systematically complied to cultural stereotypes of femininity without any uneasiness, whereas the nontranssexuals could be subdivided into two groups, those with a vague sense of ill-being linked to a pronounced feminine identity or those with only a slight feminine identity and who showed no particular difficulties.

13. National Library of Medicine: Is there evidence of health benefit from medical and surgical therapies for transsexuals

Bodlund, O. and G. Kullgren (1996). "Transsexualism--general outcome and prognostic factors: a five-year follow-up study of nineteen transsexuals in the process of changing sex." *Arch Sex Behav* **25**(3): 303-16.

Nineteen transsexuals, approved for sex reassignment, were followed-up after 5 years. Outcome was evaluated as changes in seven areas of social, psychological, and psychiatric functioning. At baseline the patients were evaluated according to axis I, II, V (DSM-III-R), SCID screen, SASB (Structural Analysis of Social Behavior), and DMT (Defense Mechanism Test). At follow-up all but 1 were treated with contrary sex hormones, 12 had completed sex reassignment surgery, and 3 females were waiting for phalloplasty. **One male transsexual regretted the decision to change sex and had quit the process. Two transsexuals had still not had any surgery due to older age or ambivalence. Overall, 68% (n = 13) had improved in at least two areas of functioning. In 3 cases (16%) outcome were judged as unsatisfactory and one of those regarded sex change as a**

failure. Another 3 patients were mainly unchanged after 5 years. Female transsexuals had a slightly better outcome, especially concerning establishing and maintaining partnerships and improvement in socio-economic status compared to male transsexuals. Baseline factors associated with negative outcome (unchanged or worsened) were presence of a personality disorder and high number of fulfilled axis II criteria. SCID screen assessments had high prognostic power. Negative self-image, according to SASB, predicted a negative outcome, whereas DMT variables were not correlated to outcome.

Cohen-Kettenis, P. T. and S. H. van Goozen (1997). "Sex reassignment of adolescent transsexuals: a follow-up study." *J Am Acad Child Adolesc Psychiatry* **36**(2): 263-71.

OBJECTIVE: To investigate postoperative functioning of the first 22 consecutive adolescent transsexual patients of our gender clinic who underwent sex reassignment surgery. **METHOD:** The subjects were interviewed by an independent psychologist and filled out a test battery containing questionnaires on their psychological, social, and sexual functioning. All subjects had undergone surgery no less than 1 year before the study took place. Twelve subjects had started hormone treatment between 16 and 18 years of age. The posttreatment data of each patient were compared with his or her own pretreatment data.

RESULTS: **Postoperatively the group was no longer gender-dysphoric; they scored in the normal range with respect to a number of different psychological measures and they were socially functioning quite well. Not a single subject expressed feelings of regret concerning the decision to undergo sex reassignment.**

CONCLUSIONS: **Starting the sex reassignment procedure before adulthood results in favorable postoperative functioning, provided that careful diagnosis takes place in a specialized gender team and that the criteria for starting the procedure early are stringent.**

De Sutter, P. (2001). "Gender reassignment and assisted reproduction: present and future reproductive options for transsexual people." *Hum Reprod* **16**(4): 612-4.

Transsexual people who want transition to their desired gender have to undergo hormonal and surgical treatments, which lead to irreversible loss of their reproductive potential. **This paper argues that transsexual people should be offered the same options as any person that risks losing their germ cells because of treatment for a malignant disease.** Indeed, transsexual women (male-to-female transsexual patients) may be given the option to store spermatozoa before they start hormonal therapy, so that their gametes may be used in future relationships. This may be especially important for the many transsexual women who identify as lesbians after their transition. **Conversely, transsexual men (female-to-male transsexual patients) may be offered storage of oocytes or ovarian tissue, possibly obtained at the time of their oophorectomy. Current technology offers transsexual people the possibility to obtain children who are genetically their own in their future relationships and the option of gamete banking should therefore be discussed before starting hormonal and surgical reassignment treatment. This is particularly important for transsexual people who are diagnosed and treated at a young age.**

Gallarda, T., I. Amado, et al. (1997). "[The transsexualism syndrome: clinical aspects and therapeutic prospects]." *Encephale* **23**(5): 321-6.

The prevalence rate of transsexualism varies from 1 to 50,000, to 1 to 100,000. Although it remains an infrequent affliction, transsexualism generates usually major suffering and may be responsible of many complications like suicide, self-mutilations, affective disorders and social

disabilities. Since the first descriptions of Esquirol in the nineteenth, the medical community has always been questioned on medical, legal, social or ethical aspects of transsexualism. The aetiology of the trouble is still unknown. In the absence of biological marker, the syndrome of transsexualism can be defined only with clinical criteria. The main differential diagnosis are sexual ambiguities and psychotic disorders. For the specialists, satisfying the patients demand of a surgical and social reassignment still remains the only way to improve their clinical condition and avoid the onset of many dramatic complications. Without any treatment, the evolution of the trouble is chronic, without remission. **Longitudinal studies of transsexual patients with a five year follow-up demonstrated subjective improvement in two thirds of the patients and don't find either higher rates of suicides nor psychotic decompensations after surgery and hormonotherapy. Clinical and neuropsychological studies of sexually differentiated cognitive abilities of transsexual patients, before and after hormonotherapy, could allow us in improving the understanding of sexual differences of the brain.**

Haraldsen, I. R. and A. A. Dahl (2000). "Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults." *Acta Psychiatr Scand* **102**(4): 276-81.

OBJECTIVE: Gender dysphoric patients of transsexual type (TS) have been considered to have severe psychopathology. However, these notions have a weak empirical documentation. **METHOD:** TS patients (n = 86), patients with personality disorder (PD, n = 98) and adult healthy controls (HC, n = 1068) were compared by means of the Symptom Checklist 90 (SCL-90). All patients were diagnosed by structured interviews (Axis I, II and V of DSM-III-R/IV). PD patients were further characterized according to the LEAD-standard. **RESULTS:** TS patients scored significantly lower than PD patients on the Global Symptom Index and all SCL-90 subscales. Although the TS group generally scored slightly higher than the HC group, all scores were within the normal range. **CONCLUSION: TS patients selected for sex reassignment showed a relatively low level of self-rated psychopathology before and after treatment. This finding casts doubt on the view that transsexualism is a severe mental disorder.**

Hepp, U., R. Klaghofer, et al. (2002). "[Treatment follow-up of transsexual patients. A catamnestic study]." *Nervenarzt* **73**(3): 283-8.

In a retrospective study, 33 transsexual patients, 22 male-to-female transsexual (MF-TS), and 11 female-to-male transsexuals (FM-TS), were interviewed 53-121 months after their first referral to the psychiatric department of a university hospital. Social integration proved to be satisfactory and relatively stable. Twenty-five patients had gone through surgical sex reassignment, while 29 were currently undergoing hormonal treatment. Regarding the course of treatment, the FM-TS were a more homogeneous group than the MF-TS group. **Overall, physical and psychosocial well-being was satisfactory. Psychometric measures yielded remarkably normal values, with some pathological findings regarding personality traits. In the majority of patients, self- and observer-rating appraisals of gender-specific physical appearance were equally positive. The results suggest a three-step procedure for the treatment of transsexual patients, as is practiced in other centers within German speaking continental Europe.**

Lief, H. I. and L. Hubschman (1993). "Orgasm in the postoperative transsexual." *Arch Sex Behav* **22**(2): 145-55.

The dearth of information regarding orgasm in postoperative transsexuals prompted the authors to study its prevalence. The sample consisted of 14 male-to-female (M-F) and 9 female-to-male (F-M) postoperative transsexuals. The relationship of orgasm to sexual and general satisfaction was explored via a specially designed questionnaire. Orgastic capacity declined in the M-F group and increased in the (F-M) group. Despite the decrease in orgasm in the M-F group, satisfaction with sex and general satisfaction with the results of surgery were high in both groups. **General satisfaction of 86% replicates other studies. Frequency of sex increased by 75% in the M-F group and by 100% in the F-M group. A phalloplasty does not appear to be a critical factor in orgasm or in sexual satisfaction. The general conclusion is reached that it is possible to change one's body image and sexual identity and be sexually satisfied despite inadequate sexual functioning.**

Miach, P. P., E. F. Berah, et al. (2000). "Utility of the MMPI-2 in assessing gender dysphoric patients." *J Pers Assess* **75**(2): 268-79.

We compared MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) profiles of 2 groups of adult biological men requesting sex reassignment surgery; 1 group was diagnosed with Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev. [DSM-III-R]; American Psychiatric Association, 1987) transsexualism and the other with gender identity disorder of adolescence and adulthood, nontranssexual type (GIDAANT). **Although the mean profiles for the transsexual group did not demonstrate any psychopathology, the GIDAANT group showed moderate psychopathology. A cluster analysis indicated that 85% of the transsexual group showed low psychopathology and 47% of the GIDAANT group showed severe psychopathology. Neither the MMPI-2 results nor the DSM-III-R clinical evaluation support the conclusion of many authors that transsexualism is associated with severe personality disorder; rather, the data indicate that transsexualism and other gender identity disorders without persistent wish for sex reassignment differ significantly in degree of psychopathology.**

Michel, A., M. Ansseau, et al. (2002). "The transsexual: what about the future?" *Eur Psychiatry* **17**(6): 353-62.

Since the 1950s, sexual surgical reassignments have been frequently carried out. As this surgical therapeutic procedure is controversial, it seems important to explore the actual consequences of such an intervention and objectively evaluate its relevance. In this context, we have carried out a review of the literature. After looking at the methodological limitations of follow-up studies, the psychological, sexual, social, and professional futures of the individuals subject to a transsexual operation are presented. **Finally, prognostic aspects are considered. In the literature, follow-up studies tend to show that surgical transformations have positive consequences for the subjects. In the majority of cases, transsexuals are very satisfied with their intervention and any difficulties experienced are often temporary and disappear within a year after the surgical transformation. Studies show that there is less than 1% of regrets, and a little more than 1% of suicides among operated subjects. The empirical research does not confirm the opinion that suicide is strongly associated with surgical transformation.**

Rehman, J., S. Lazer, et al. (1999). "The reported sex and surgery satisfactions of 28 postoperative male-to- female transsexual patients." *Arch Sex Behav* **28**(1): 71-89.

From 1980 to July 1997 sixty-one male-to-female gender transformation surgeries were performed at our university center by one author (A.M.). Data were collected from patients who had surgery up to 1994 (n = 47) to obtain a minimum follow-up of 3 years; 28 patients were contacted. A mail questionnaire was supplemented by personal interviews with 11 patients and telephone interviews with remaining patients to obtain and clarify additional information. **Physical and functional results of surgery were judged to be good, with few patients requiring additional corrective surgery. General satisfaction was expressed over the quality of cosmetic (normal appearing genitalia) and functional (ability to perceive orgasm) results. Follow-up showed satisfied who believed they had normal appearing genitalia and the ability to experience orgasm. Most patients were able to return to their jobs and live a more satisfactory social and personal life. One significant outcome was the importance of proper preparation of patients for surgery and especially the need for additional postoperative psychotherapy. None of the patients regretted having had surgery.** However, some were, to a degree, disappointed because of difficulties experienced postoperatively in adjusting satisfactorily as women both in their relationships with men and in living their lives generally as women. Findings of this study make a strong case for making a change in the Harry Benjamin Standards of Care to include a period of postoperative psychotherapy.

Tsoi, W. F. (1993). "Follow-up study of transsexuals after sex-reassignment surgery." *Singapore Med J* **34**(6): 515-7.

INTRODUCTION: This is a follow-up study of 45 male and 36 female sex reassigned transsexuals. METHOD: The subjects were interviewed before and 1 to 8 years following sex reassignment surgery. RESULTS: When first seen the males (mean age 23.8 years) were slightly younger than females (mean age 24.9 years). The males had less education and held lower level jobs. They started their sexual life about 1-2 years earlier, but they cross-dressed 4-7 years later than the females. **The follow-up results showed that 35% were married and all of them had no problems adjusting to their new life. The overall results were 56% very good and 44% good.** There is no pre-operative variables that can predict good adjustments for female transsexuals. **For male transsexuals, earlier age of transsexual manifestation was related to good post-operative adjustments.** DISCUSSION: The females were less satisfied with the surgery, but they adjusted well as the males. The results were comparable with those from previous studies.

van Kesteren, P. J., H. Asscheman, et al. (1997). "Mortality and morbidity in transsexual subjects treated with cross-sex hormones." *Clin Endocrinol (Oxf)* **47**(3): 337-42.

OBJECTIVE: The optimum steroid hormone treatment regimes for transsexual subjects has not yet been established. We have investigated the mortality and morbidity figures in a large group of transsexual subjects receiving cross-sex hormone treatment. DESIGN: A retrospective, descriptive study in a university teaching hospital. SUBJECTS: Eight hundred and sixteen male-to-female (M-->F) and 293 female-to-male (F-->M) transsexuals. INTERVENTIONS: Subjects had been treated with cross-sex hormones for a total of 10,152 patient-years. OUTCOME MEASURES: Standardized mortality and incidence ratios were calculated from the general Dutch population (age- and gender-adjusted) and were also compared to side effects of cross-sex hormones in transsexuals reported in the literature. RESULTS: In both the M-->F and F-->M transsexuals, total mortality was not higher than in the general population and, largely, the observed mortality could not be related to hormone treatment. Venous thromboembolism was the major

complication in M-->F transsexuals treated with oral oestrogens and anti-androgens, but fewer cases were observed since the introduction of transdermal oestradiol in the treatment of transsexuals over 40 years of age. No cases of breast carcinoma but one case of prostatic carcinoma were encountered in our population. No serious morbidity was observed which could be related to androgen treatment in the F-->M transsexuals. CONCLUSION:

Mortality in male-to-female and female-to-male transsexuals is not increased during cross-sex hormone treatment. Transdermal oestradiol administration is recommended in male-to-female transsexuals, particularly in the population over 40 years in whom a high incidence of venous thromboembolism was observed with oral oestrogens. **It seems that in view of the deep psychological needs of transsexuals to undergo sex reassignment, our treatment schedule of cross-sex hormone administration is acceptably safe.**