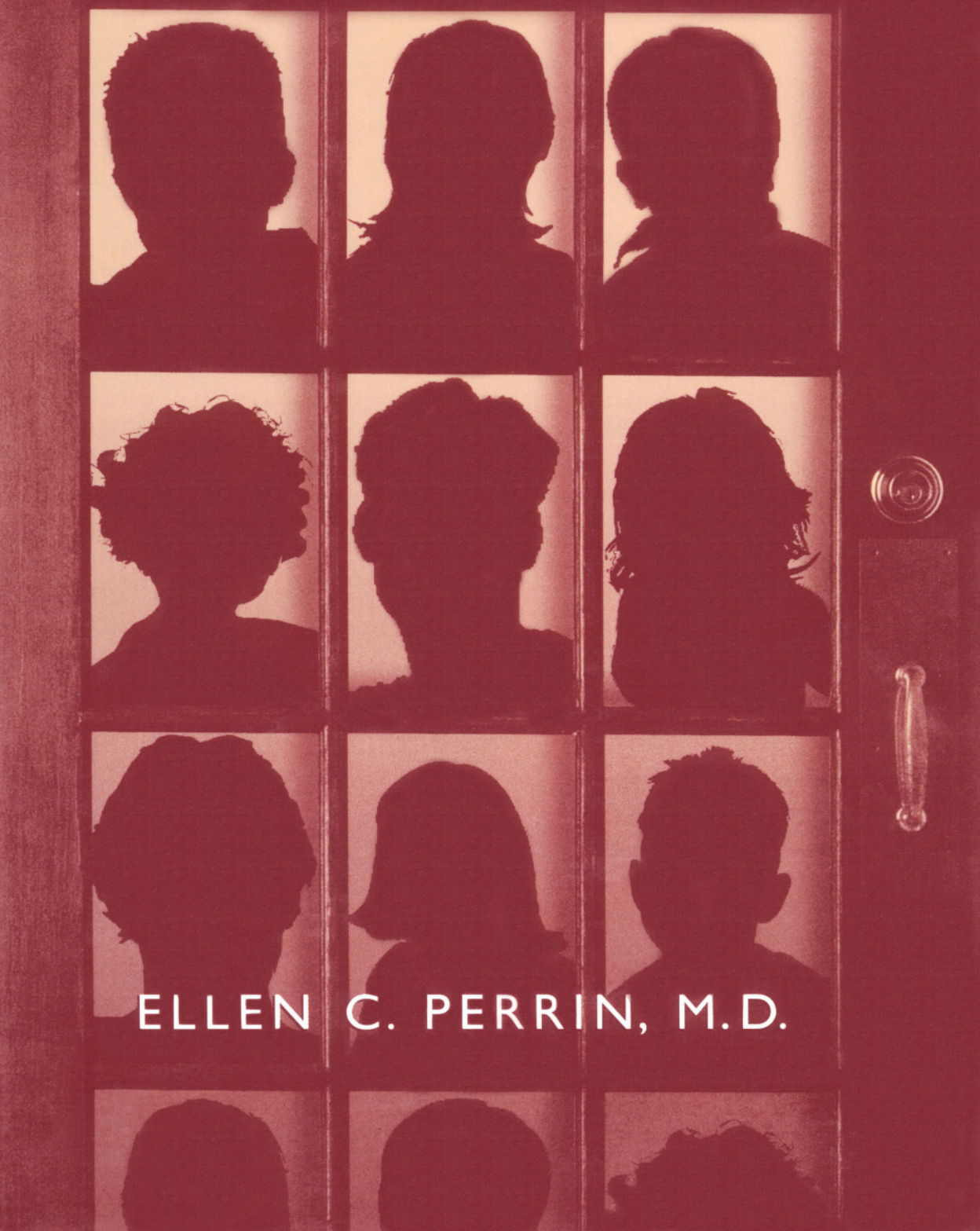
SEXUAL ORIENTATION IN CHILD AND ADOLESCENT HEALTH CARE



ELLEN C. PERRIN, M.D.

Sexual Orientation in Child and Adolescent Health Care

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KLUWER ACADEMIC PUBLISHERS
NEW YORK, BOSTON, DORDRECHT, LONDON, MOSCOW

eBook ISBN: 0-306-47643-6
Print ISBN: 0-306-46761-5

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For Andy and Ben, forever my best teachers

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Acknowledgements

It was a long and circuitous path that led to the completion of this volume. Along the way I appreciated the considerable guidance, support, and wisdom I received from many friends and colleagues. This book would have been very different without their contributions, if indeed it had come to exist at all. I thank you all for your part in the journey, and I hope that you are at least satisfied with its resting place.

Special thanks are due to Bill Cohen, Sarah Cohen, Liz Coolidge, Murray Kappelman, Anne Kazak, and Stanley Sack. They helped me to formulate and crystallize my ideas, provided information and insight, made perceptive and helpful comments on various drafts of various chapters, and gave me continuing encouragement. As student, colleague, and friend, Jannette McMenamy deserves extra gratitude for her persistent support, enthusiasm, and wise suggestions about both substance and style. Adrienne Asch especially helped me to understand stigma and its effects, and how pervasively it affects us all. Fern Miller knows how bumpy was the road between my idea to write this book and its completion, helped me steer around the obstacles, and was always a supportive cheerleader.

My mother did not live to know of this project; although I imagine that we might have argued about various aspects of it I trust that she would have applauded its intent. I appreciate the lifelong learning I received from her and her mother, and from my father, about the importance of idealism, determination, and commitment to justice.

Without the persistence, care, and enthusiasm of Virginia Gow the ideas would never have become a manuscript. Her patience and skill in taking my notes, dictations, and heavily edited drafts through to a final form have been remarkable, and her good cheer sustaining. Thank you.

Last but not least I do as always thank Jim Perrin for his constant support, his faith in me, and his patience with all the sacrifices that this process has required.

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Foreword

1.

The challenges associated with the development of sexual identity and behavior are central to child and adolescent health care. Although often hidden, sexuality exists as a critical aspect of health care providers' interactions with their patients at all ages. By adolescence these issues take center stage. Both primary care providers and subspecialists who deal with adolescents must not only be knowledgeable about the range of sexual orientation, but also be aware of their own attitudes about that range. Recent data describing the continuing prevalence of HIV infection and of suicide among gay adolescents highlight the various health risks these adolescents face.

In addition to adolescents, child health care providers are caring for increasing numbers of patients who have a gay or a lesbian parent, or have been born to or adopted by a gay or lesbian couple. These families encounter all the usual challenges of parenting and in addition may have special concerns based on their family constellation. Parents and children may welcome caring guidance about experiences of stigma, discrimination, and misunderstanding.

Raising many strong emotions, the issue of homosexuality is buffeted by myths, misinformation, and often intense societal judgment. The neglect of sexuality in medical education and in medical care have led to ignorance of important risks, discrimination against sexual minority students and practitioners, and marginalization of research about the concerns of gay and lesbian teens and their families, and gay and lesbian parents and their children. Traditional pediatric and adolescent medicine textbooks address the development of sexual orientation and the issues of gay and lesbian individuals and their families cursorily at best.

In welcome contrast, this well researched and written book by Ellen Perrin focuses on the whole range of relevant topics. Anyone who knows Ellen is aware that she never shies away from controversial topics, especially when the mental and physical health of all children and youth are concerned. This book is no exception. In a thoughtful, balanced manner, she presents us with the gamut of ways that issues related to homosexuality affect child and adolescent health care. She addresses problems in medical education, discusses the paradox of so-called "gender identity disorder", describes the risks faced by gay and lesbian adolescents, and provides a summary of the latest research about children whose parents are gay or lesbian. She is passionate about the expansive role of pediatricians and other child health care professionals: these issues, she insists, are important for all children, all adolescents, all parents. But this is not a theoretical academic treatise; Ellen Perrin applies her first-hand clinical experience to provide practical, concrete suggestions to address the problems she describes. She provides also a comprehensive listing of reading materials, organizations, and videos that will be valuable resources to parents, teenagers, and pediatricians who are curious about issues of sexual orientation.

As health care providers of the twenty-first century, we should all read and heed the wisdom and perspective that this textbook gives us. It will help us to be better, more complete providers to all our patients, parents, and colleagues, regardless of their sexual orientation.

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It seems ironic that an aspect of health and life that is intimately connected to human development, well-being, reproduction and risk gets so little attention in medical and professional training. Even after two decades of the AIDS epidemic, sexuality still is overlooked frequently in the course of clinical care and service delivery. Many physicians and other clinicians fail to take a careful sexual history including sexual orientation. And yet this most basic aspect of assessment provides critical information about potential risks, stressors and experiences that are essential for appropriate care, while opening a door for communication, disclosure and trust that are basic elements of the patient-clinician relationship.

Since the 1970s, we have learned a great deal about sexual orientation, including new and important information on adult and adolescent development, the impact of stigma on behavior and risk, the emergence of openly lesbian and gay families, appropriate treatment and cultural competence with lesbian, gay, bisexual and transgender patients, and the experiences of lesbians and gay men across the life course. The AIDS epidemic has driven new empirical research, largely on epidemiology and behavioral risks, but also on appropriate treatment and assessment. Because sexuality is a complex phenomenon, important information related to sexuality is published in a wide range of journals and books. Unfortunately, this multidisciplinary literature is rarely synthesized for physicians and other professionals who work with children, youth, adults and families.

Sexual Orientation in *Child and Adolescent Health Care* is the first publication to bring together information from these diverse professional literatures related to health and mental health care for lesbian, gay and bisexual children, youth, adults and families. Written for pediatricians and other health and mental health providers, it approaches care in the context of families and reminds practitioners that sexual identity and sexual prejudice affect family systems as well as individuals. Through an in-depth review of the most recent literature on sexual orientation, health concerns, and lesbian and gay families, author and pediatrician Ellen Perrin provides a multi-dimensional framework for incorporating sexuality into all aspects of care, thus improving the quality of care for all patients. Her clinical insights and experiences add essential practical guidance for pediatricians and other clinicians working with children, youth, and families.

At the same time, Dr. Perrin models the role of physician advocate through her own teaching, training, and community advocacy work. She identifies a variety of roles that pediatricians and other providers can play to improve the lives of lesbians and gay men of all ages, from encouraging school and community libraries to carry books related to sexual orientation to advocating for visibility and appropriate care in professional associations. Dr. Perrin also tackles medical education and provides practical suggestions for enhancing the curricula and for providing training, while improving and sensitizing care in clinics, hospitals and physicians' offices.

Sexual Orientation in *Child and Adolescent Health Care* is an important resource for pediatricians, family physicians, psychiatrists, nurses, social workers, psychologists and others who work with children, youth and families. By focusing on families and family-centered care this book helps to humanize sexual minority patients and dispels a long-standing myth that places gay people outside the family system—a myth that has limited life chances and options for many gay children and adolescents who have felt isolated, separate, and apart from their heterosexual peers and who have struggled to protect their emerging sexual identity from rejection, victimization and violence. Recent research has shown that gay youth frequently become aware of same-sex attraction and "come out" at much earlier ages than did previous generations of lesbian and gay adults. "Coming out" during adolescence increases stress for youth and families, and increases the likelihood of victimization and abuse (even in families) for lesbian, gay and bisexual youth. At the same time it provides an opportunity for gay teens to integrate their sexual identity during their adolescence and thus to experience normative developmental milestones along with their peers.

Pediatricians and other clinicians can play a critical role in helping adolescents and families deal with what for too many is still a distressing and confusing experience. They can help gay youth develop positive coping skills, self-care, and help-seeking behaviors. They can help parents and youth anticipate normative developmental tasks and additional challenges related to having a stigmatized identity. And they can help parents and youth understand that having children and a family and having a satisfying career—options that were so often foreclosed by prejudice and homophobia for older lesbians and gay men—are viable options for sexual minority youth today.

Pediatricians can also play an important role in helping lesbian and gay parents cope with stigma and unresponsive systems, and provide support for their children in learning to deal with ignorance and discrimination.

Because sexuality impacts all aspects of a person's life, it is one of the most important issues for pediatricians and other providers to address. This book makes an important contribution to ensuring that they are up to the task.

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Introduction

HOW THIS BOOK CAME TO BE

I was in high school when the movement to ensure civil rights for people of color began. I was outraged at the violations of basic principles that were highlighted by that struggle. How could this country that had rescued my parents from the holocaust and considered itself the beacon of freedom and justice in the world allow such blatant transgressions of basic human rights?

At first I just didn't believe it. They must be exaggerating the problem; there couldn't actually be laws that prevented children with dark skin from going to the same schools as white children, or eating in the same restaurants, or riding the same buses. But they were not exaggerating, and beyond the laws was even more injustice ingrained in the routines of everyday life. I joined the picket lines at Woolworth stores, worked on boycotts, wrote letters, and idolized Martin Luther King Jr. Some years later I joined many others in protesting the injustice of the Viet Nam war, and later still worked in the large effort to help the citizens of South Africa free themselves from apartheid. Perhaps it has all made some difference—my small efforts joining with those of many others to insist on equity and justice.

This book is the result of my awakening to the stigmatizing attitudes and unfair treatment still tolerated with regard to people whose sexual attractions and behaviors are not heterosexual. Just as when I was younger, I didn't believe it at first. About a decade ago, two clinical dilemmas were presented by thoughtful pediatricians at a discussion group about psychosocial issues that I was leading. One concerned a young adolescent whose parents worried about his gender-atypical behavior; the other was a child whose mothers had asked her advice about special considerations involved in parenting their child. Together we muddled through learning what we could about emerging homosexuality, issues faced by adolescents who are not heterosexual, and children whose parents were of the same sex.

Shortly thereafter—coincidentally—as the most junior member of a committee of the American Academy of Pediatrics, I was assigned to research what we knew about children whose parents were gay or lesbian. I learned that there had been absolutely nothing published in the pediatric literature about these children, despite a growing knowledge base published in the professional literatures of psychology, social work, and nursing. Therein seemed a worthwhile challenge.

Then I was hooked; here was another effort, just beginning, to ensure the civil rights of certain citizens in the face of stigmatization and hostility. As a

pediatrician I pondered whether the effort to achieve civil rights for gay men and lesbians was truly in the purview of pediatrics. After some reflection I assured myself that gay and lesbian issues are indeed a legitimate part of pediatric care, for several reasons. (1) The age at which adolescents are questioning and coming to understand their sexuality, and recognizing their sexual orientation, is increasingly younger; (2) the upper age limit of pediatrics has increased to at least 18 and for some 21—well above the age at which the majority of gay men and a sizable number of lesbian women recognize their homosexuality; and (3) advances in reproductive and social possibilities have led to a rapid escalation in the number of children (our patients) who have one or more homosexual parent(s).

Furthermore, (4) I recognize increasingly the power of child health professionals as opinion leaders in their professional and community roles. If *we* don't speak out against injustice to children and families, who will? I came to believe that as pediatricians we are obligated to learn about and to teach about and to advocate for gay and lesbian youth and their parents, and for gay and lesbian parents and their kids. It is up to us to join in solidarity with all others who would work together to confront stigma and break down the barriers of discrimination. I hope that this volume will make a small step in that direction.

DEFINITIONS OF TERMINOLOGY

There are twenty words in Norwegian for our single word "snow. Language reflects values, experience, the sophistication of understanding. In the realm of homosexuality there are many confusing, misunderstood, and missing words. We have no word for the functional equivalent of a 'spouse', for example—'partner' is the commonly accepted substitute but creates new confusion when it is not clear if the partner is in business or in bed. We have no language for a second parent if she is not a father, nor for the relationship of a child to the extended family of her two adoptive fathers. In this book I have tried to use words that describe functions and relationships, recognizing their inadequacy.

The word 'homophobia' originated as a description of the fear aroused in heterosexuals when they encountered a homosexual individual. The fear grew out of stigma, lack of familiarity, and awkwardness, and the word itself came to include all of those phenomena in addition to its original meaning. A new term was needed—one that did not reflect individual reactions but rather the social assumptions that guided individual actions. 'Heterosexism' describes the belief that only a heterosexual orientation is normal. The confluence of both social assumptions and individual reactivity can be summarized by the less familiar term 'homonegativity'.

The language for people whose orientation is not heterosexual is confusing as well. I have used the terms "gay" and "lesbian" throughout, recognizing that some consider themselves truly bisexual. While some advocates and some authors would include people who are transgender in these discussions,

I believe the phenomena associated with transgenderism to be sufficiently different from those involved in homosexuality to require different analyses.

Other words have been created and moved into common usage without formal definition, thus often used incorrectly or misunderstood. The Table contains a number of words and their working definitions, so at least among readers of this book we can all "say what we mean and mean what we say".

TABLE Definitions of Terms

Sexual orientation: A persistent pattern of physical and emotional attraction to members of the same and/or opposite sex. Components include sexual fantasy, emotional attraction, sexual behavior, and self-identification.

Homosexuality: A persistent pattern of same-sex arousal accompanied by weak or absent arousal to members of the opposite sex

Lesbian: Popular term for homosexual female
Gay: Popular term for homosexual male

Heterosexuality: A persistent pattern of arousal to members of the opposite sex in the presence of weak or absent arousal to members of the same sex.

Straight: Slang term for heterosexual (male or female)

Transsexuality (Transgenderism): An incongruence between biological sex and self-perceived gender identity. Individuals feel 'trapped' in the body of the opposite sex and may seek to alter their physical appearance accordingly. May be heterosexual or homosexual.

Bisexuality: A pattern of arousal toward people of either sex.

Transvestism: Dressing in the clothing usually characteristic of the opposite sex; not an indication of sexual orientation.

Homonegativity: Discomfort, dislike, or critical judgment about people who are not heterosexual.

Homophobia: Fear or hatred of people who are homosexual.
Heterosexism: The belief that only a heterosexual orientation is 'natural' and normal.

Sex: The classification of individuals as 'male' and 'female' on the basis of internal and external reproductive organs and their sexual functions.

Gender identity: The personal perception of oneself as 'male' or 'female'

Gender role: The outward expression of gender identity; behaviors and appearance that signal to others one's sense of being male or female.

Coming out: The process through which individuals who are not heterosexual come to terms with their sexual orientation, integrate it within their lives, and disclose it to others.

Partner: Term used for an intimate partner, roughly equivalent to 'spouse'

Biologic mother/father: A person who is genetically responsible for the creation of a child. Often abbreviated "biomom"/"biodad".

Coparent: The partner of a biologic or adoptive parent who shares in the responsibilities of parenting.

OVERVIEW OF THE BOOK

This volume consists of an idiosyncratic amalgam of the issues I consider important for practitioners of child health care to contemplate. The first chapter defines the pervasive social phenomenon that I have come to believe underlies most of the varied problems faced by non-heterosexual children and adults: stigma. Stigma separates people from one another—even parents from their children. Stigma diminishes people's self-esteem, is at the base of many mental health disorders, and renders invisible a segment of the population.

The second chapter outlines the effects of stigma on medical care contexts: how physicians view their patients, patients their physicians, and physicians each other, based on the single characteristic of their sexual orientation. The chapter outlines the broad effects of the stigmatization of homosexuality on medical education and research.

The third chapter addresses several developmental themes: early evidence of a non-heterosexual orientation, the factors that contribute to the development of sexual orientation, and the broad stages in the unfolding of a homosexual identity during the adolescent years.

The fourth chapter focuses on adolescents—those who know they are or wonder if they are gay or lesbian, and the role of clinicians in discussing homosexuality with all adolescent patients. I note the important role of child health professionals in assisting parents and other family members faced with reorienting their vision of their adolescent after s/he discloses his/her homosexuality.

In the fifth chapter I present the accumulated evidence regarding the status of children who have one or more parent(s) who is/are lesbian or gay. The last decade has seen an explosion of research in this realm. The research initially focused on the level and type of risk that non-traditional family structures and homosexual parents created for children. Finding none, inquiry more recently has moved to discover the characteristics of these non-traditional families that confer particular risks and benefits on their children.

The sixth chapter is a call to action. I outline the four types of responsibilities I see for pediatricians and other child health practitioners. I believe they can act on the community level, in the context of the hospitals and offices they work in, in the direct clinical work they do, and in improving the content of medical care, education and research regarding homosexuality.

In the last chapter I provide a briefly annotated listing of some of my favorite resources. I have included books for adults and for children of various ages, both fiction and non-fiction, and videotapes. Both books and videos are selected from an extensive collection that has become available only in the past decade, which provides a valuable resource for people who used to think they were alone in their personal struggles with their sexual orientation. I have listed also the contact information for some national organizations that provide information, support, and guidance. I hope that this chapter will become a handy reference for clinicians to draw upon when faced with a patient, colleague, or student for whom these resources might be helpful.

1

Stigma

Before I built a wall I'd ask to know
What I was walling in or walling out,
And to whom I was like to give offense.
Something there is that doesn't love a wall,
That wants it down.

Robert Frost, Mending Wall

Homosexuality is a personal characteristic that is pervasively stigmatized. This stigma results in many of the difficulties that confront gay men and lesbians, their children, their parents, their siblings, and even children who display some qualities taken to be suggestive of early homosexuality. Stigma leads to discrimination, and discrimination marginalizes and devalues people. To understand the issues that will be described later in this book, it is important first to contemplate the sources of stigma and its effects more generically.

DEFINITION AND EXPLICATION

Stigma is based on stereotypes. Webster's International Dictionary defines "stereotype" as "a standardized mental picture representing an oversimplified opinion, affective attitude, or uncritical judgment of a person, a race, an issue or an event." Generalization devoid of judgment is generally adaptive and helps everyone understand the world. We learn that certain characteristics define a chair, others a vehicle, and still others an animal. A great deal of variation of detail is tolerated within each category. For example, if chair-ness consists ordinarily of an object that has 4 legs and a surface for sitting, we accept that some chairs nevertheless have 3 or 5 legs. Human-ness generally includes standing and walking on 2 legs, but a person with only one leg is unquestionably human nevertheless. In both cases, the number of legs is not

taken to mean anything about the subject other than its leg structure. Stereotyping occurs when this process of generalization is expanded to include a judgment about the broader nature of the subject based only on a single characteristic. For example, 3-legged chairs are inherently beautiful or uncomfortable; people with a leg amputation are surly or smart.

Humans are made up of a more-or-less random collection of a huge number of physical and psychological characteristics. The process of stereotyping takes one of these characteristics and elevates it to encompass the whole person, ignoring the full complexity of the individual. A further step in generalization occurs when a particular characteristic is assumed to exist in common among an entire category of persons, in essence attaching a judgment about an isolated attribute of one individual to all people who share some similar characteristics. Stereotypes can be positive (Asians are high achievers; gay men are artistic) or negative (women are fickle; African-Americans are lazy). In either case, though, people are treated as categories rather than as individuals, and in the process their individuality is depreciated (Ainlay & Crosby, 1986). Saying that "she is a redhead" calls up a set of assumptions and generalizations about a category of people, while "she has red hair" does not. Consider the difference in the breadth of associations called up by the statements "she is handicapped" versus "she uses a wheelchair."

Negative stereotypes readily fuel stigmatization. "Stigma" is defined in Webster's as "a mark of shame or discredit; a label indicating deviation from a norm." The word originated in the classic Greek practice of cutting or burning into a person's body some sign to expose something unusual or bad about his/her moral status, used for example for people designated as slaves, criminals, and traitors. When a single characteristic is allowed to represent the whole person (stereotyping), and that isolated characteristic is devalued by the society or subculture, the person is *stigmatized.* Applied to categories of persons who share a particular characteristic, the categories themselves can be said to be systematically stigmatized. Readily-recognized examples include people with dark skin color, people who speak with an accent foreign to their community, people of particular religions. In the wake of the attack on the World Trade Center in September, 2001, all people of Arab descent were subject to stigmatization as possible terrorists.

In his classic essay, *Stigma: Notes on the Management of a Spoiled Identity* (1963), Erving Goffman defined stigma as "an attribute that is deeply discrediting" (which he calls a "mark"). He recognized that this definition is of limited use in understanding its social and psychological effects and acknowledged that "a language of relationships, not attributes, is really needed". No particular characteristic is stigmatizing per se; it is only when a characteristic is transformed into a normative requirement by a society or group that it takes on special significance. Furthermore, the negative effects of stigmatization on both the persons with and those without the "mark" do not arise from the "mark" itself but from the social and psychological consequences of the process of stigmatization.

Stigma represents the negative reactions of people who do not possess a particular characteristic to those who do. As such, stigma embodies the view

that *difference* is *deficit.* In fact, some authors have described stigma as "a response to the dilemma of difference" (Coleman, 1986). Stigma defined more broadly, then, is based on social comparison and creates a socially-defined interactional relationship between a dominant group and a group that is defined as less good. It sets up a fundamentally superior-inferior relationship based on some intrinsic characteristic or "mark." The characteristic need not be visible or even a permanent attribute; anything that is seen as aberrant or different can result in stigma (Stafford & Scott, 1986).

We may even fail to notice anything about people beyond their possession of the stigmatizing characteristic. For example, people with disabilities often experience profound isolation because they are typically avoided in social contexts. We don't even make an effort to learn about their person-ness—their name, their interests, their concerns—focusing only on the fact that they have a particular disability. This tendency is evident in language that defines people by their stigmatizing characteristic: e.g., "the poor", "the blind", "the mentally ill." A particularly destructive but common byproduct of such social judgments is the internalization of the stigma by individuals who are affected, in effect accepting the devaluation and discrimination they experience.

Significant pressure is often exerted to "normalize" those who are outside of a cultural standard. According to the Greek legend, Procrustes placed all people who fell into his hands on an iron bed. If they were longer than the bed he chopped off the overhanging parts. If they were shorter, he stretched them until they fit. Clearly the legend depicts an absurd extreme, but it has become apocryphal for the forceful fitting of people to a single standard.

Stigmatization is often unintentional. Social stereotyping is so powerful that it transcends individual recognition. Stigmatization is fundamentally reflective of an unequal distribution of power with regard to a particular characteristic; those who are unaffected generally do not even notice its effects. Richard Delgado wrote, for example, "Because racism is an ingrained feature of our landscape, it looks ordinary and natural to persons in the culture" (Delgado, 1995). No one *intended* to create inequities in health care between Caucasian patients and people of color, and yet such social disparities are documented repeatedly. When a highly qualified candidate is passed over for a job, her obesity is not consciously seen as the explanation.

WHAT CHARACTERISTICS ARE STIGMATIZED?

Stigma is more than an interpersonal process. It is determined by the broader cultural context of stereotypes, values, and ideologies, and the meanings given to particular characteristics. Characteristics that are stigmatized in a given society are fundamentally arbitrary and reflect the value judgments of the dominant groups in the society. A characteristic that is stigmatized in one society or subculture may be highly valued in another. For example, obesity is condemned in some-but not all-contemporary Western societies, but "fattening houses" were once used to produce more beautiful women (Clinard & Meier,

1979). Affiliation with Jewish religion obviously is highly valued in Israel but severely stigmatized in other societies. In communities in which the majority of individuals are deaf, communication by sign has been considered normative and spoken language a second-rate substitute (Cohen, 1994).

The phenomenon of differentiating people on the basis of particular characteristics leads to a slippery and dangerous slope. All humans differ from one another in innumerable small and large ways, possessing or not possessing various characteristics of physical and psychological makeup. Any one or more of those characteristics may labeled as "bad" and subject to ridicule, disrespect, or discrimination. Thus, all humans are potentially stigmatizable, because "human differences serve as the basis for stigmas" (Coleman, 1986). Indeed, any individual may not have a particular characteristic today but wake up one morning to find that she/he now has it, for example as a result of an illness or a traumatic injury, or through the discovery that a family member is lesbian or gay.

The particular characteristics that are targets for criticism in any particular place and time may vary, and differences often exist among subgroups within a society in the degree of disapprobation that is directed at various characteristics and their relative "badness". Consider a society in which a height over 5 feet or blue eye color was considered grotesque. A socially-defined hierarchy of "stigmatizable" characteristics may mean that height is more objectionable than eye color, but worst is being overweight. The degree of stigmatization also depends on how undesired the difference is in a particular social group. The ubiquity of human difference ensures that relative distinctions will always be possible between dominant and devalued characteristics, sanctioning discrimination and rejection of people who possess the latter.

We each carry within us some characteristics that only we know about; those aspects of our personality, our history, or our habits that are a source of some shame. We guard this knowledge carefully, lest it be cause for disrespect, disdain, and criticism were it revealed. Goffman describes the dilemma like this: "Stigma involves not so much a set of concrete individuals who can be separated into two piles, the stigmatized and the normal, as a pervasive two-role social process in which every individual participates in both roles in some connections and in some phases of life. The normal and the stigmatized are not persons, but perspectives" (Goffman, 1963). I challenge the reader to contemplate what aspects of her/his psyche and/or physique could potentially be isolated from the whole and become the subjects of ridicule, criticism, and discrimination. What characteristics have you kept hidden in order to avoid potential negative judgments? Ironically, the self-stigmatization that many of us have experienced is often harsher than that which would have ensued if we had let ourselves be known, if we had challenged the notion that *difference is deficit.*

DISTINCTIONS AMONG STIGMATIZED CHARACTERISTICS

Goffman makes a critical distinction between people who have an immediately evident "mark" which puts them at risk of being "discredited" (e.g.,

people who lack a limb or have dark skin), and people with an unknown or invisible "mark" whom he calls "discreditable" (e.g., people who have certain kinds of chronic health conditions, are of a particular religion, or are not heterosexual). The two types of characteristics are quite different in the social requirements they make on individuals. Immediately evident characteristics tend to result in insecurity about how people will respond to them, awkwardness in social discourse with people who don't have the same characteristic, and resulting isolation (Fine & Asch, 1995). Uncertainties about expectations and appropriate language constrain both those people with a particular characteristic and those without it from carrying on uncluttered communication (Hebl, Tickle, & Heatherton, 2000).

In contrast, if a person's differentness is not immediately apparent, the primary task is to "manage" information about the "discreditable" characteristic. Non-heterosexuality is generally invisible and is therefore an example of this phenomenon. The dilemma Goffman describes is "to display or not to display, to tell or not to tell, to lie or not to lie, and in each case to whom, how, when, and where" (Goffman, 1963). One discussion of the "hidden costs of hidden stigma" goes like this: "Given the choice, most of us would probably prefer that our stigmas were secret. The various social albatrosses we all carry with us would seem to be less weighty and might even fly away if no one else could see them. However, concealing a stigma leads to an inner turmoil that is remarkable for its intensity and its capacity for absorbing an individual's mental life" (Smart & Wegner, 2000). Earlier descriptions also document that withholding personal information about oneself may lead to feelings of isolation, fraud, and fear of discovery (Goffman, 1963) and can impede the development and maintenance of social relationships (Herek, 1996). Keeping a secret is often a tremendous burden and may lead to preoccupation with the secret itself and with attempts to keep it hidden (Smart & Wegner, 1999).

On the other hand, if people decide to disclose their stigmatizing characteristic in a particular interaction, they risk negative judgments that they might avoid through silence. In order to make this task of information disclosure easier, people may sometimes display visible signs of their otherwise-invisible stigma, e.g., lapel buttons or a particular style of dress. This distinction between "discrediting" and "discreditable" characteristics is critically important for our consideration later in this chapter of the special case of non-heterosexuality as a stigmatized characteristic. Gay men and lesbians may be tempted to keep their sexual orientation hidden in order to escape potential discrimination and negative judgments, and yet disclosure has been found in general to reduce stress, isolation, and their consequences for mental health.

Another important phenomenon is that of "secondary stigma." Stigma can be conferred by association, seen for example when the child of a prisoner or the sibling of a child with mental retardation are shunned by classmates. Not only is the individual disliked or devalued because of some characteristic whose significance is seen to override all other attributes he or she possesses, but his/her parents, children, and friends are included in the overgeneralization as well. A colleague describes her experience with secondary stigma: "I try

to avoid any discussions about my siblings, because I am afraid of how people will react to me when they learn that I lost a brother to suicide. Will they assume that I have a mental illness, that my parents were failures, or that my family is abnormal in some way? I don't want people to look at me differently." This "secondary stigma" can be seen to apply also to the family members of a gay/lesbian adolescent and to the children of same-sex parents (Neuberg, Smith, Hoffman, & Russell, 1994). The son of a gay man told me, for example, "I have always worried that when people found out about my dad, they wouldn't want to be my friend ... I feel like they'll see me as 'damaged goods' on account of him."

"Other imensions differentiate stigmatized characteristics as well, and may account for relative degrees of stigmatization. For example, is the characteristic a core, inborn quality of the individual? Is it shared by all members of a family (e.g., race, ethnic background)? Is it changeable (e.g., obesity, cigarette smoking)? Does it affect interpersonal relationships or are its manifestations purely personal (e.g., intellectual achievement)? Was the characteristic imposed upon the individual (e.g., a congenital health condition) or caused by his/her own actions (e.g., imprisonment, drug abuse)? The perceived controllability of the stigma may affect people's responses to it and secondarily its impact on self-esteem (Crocker & Major, 1994). If a person is judged able to remove the characteristic by his/her volition or particular actions, stigmatization may be more severe.

It is important to keep in mind also that of the infinite number of characteristics that define each individual, many may be singled out for negative judgment and discrimination at one time and place or another. To add to the complexity, the rules are not only culturally bound but changeable. For example, norms for the female figure to be extremely thin have become increasingly rigid in the past decade, raising concern in many about adverse health consequences. Cigarette smoking once was considered glamorous but currently is frowned upon. I will discuss later in this chapter how these variables may apply to the pervasive cultural stigma regarding homosexuality.

NEGATIVE CONSEQUENCES OF STIGMATIZATION

Stereotyping causes people and categories of people to be reduced to a single characteristic. Both the infinite complexity of each individual and the variations among the individuals in the group are overlooked or denied. People are homogenized, and a false commonality is assumed to exist among them. As such, the stereotype creates assumptions that a person who possesses a stigmatized characteristic is required either to accept or to actively dispel. This process of countering the assumptions of others is expensive of psychological energy and is fundamentally demeaning. For the persons who do not possess the stigmatized characteristic, the process separates them from those who do and deprives them of the benefits of knowing them fully.

A person who is stigmatized "is a person whose social identity, or membership in some social category, calls into question his or her full humanity—the person is devalued, spoiled, or flawed in the eyes of others" (Crocker, Major, & Steele, 1998). Stigma creates a sense of personal failure or inferiority. People who possess a particular characteristic are seen *ipso facto* as less worthy. Either directly or indirectly they receive messages of disrespect, criticism, dismissal, and rejection. Insofar as this response is seen as representative of the dominant values of the society, this message of devaluation may be internalized and as a result threaten self-esteem, and lead to emotional distress and further isolation. Stigmatized individuals may take on the view of themselves as discredited, since "the eye of others is where we seek the validation of our existence, and this is the yardstick by which we each judge our self-worth" (Lefebvre, 1996). The notion of themselves as inexplicably flawed is pervasive among people with visible or invisible characteristics that are socially devalued. In a classic essay, Fiedler wrote, "The war against 'abnormality' implies a dangerous kind of politics, which beginning with a fear of difference eventuated in a 'tyranny of the normal.' That tyranny, moreover, is sustained by creating in those outside the norm shame and self-hatred, particularly if they happen to suffer from those 'deformities' (the vast majority still) we cannot prevent or cure" (Fiedler, 1996).

Stigma exerts a powerful barrier to interpersonal relationships by marginalizing groups of individuals and fundamentally isolating people from one another. Discomfort, anxiety, and unfounded assumptions on the part of both the stigmatized person and others lead to awkward social discourse and frequent misunderstandings, and serve to perpetuate their avoidance of each other (Hebl et al., 2000). Individuals who do not possess a particular stigmatizing characteristic (the dominant subculture) tend either directly or indirectly to avoid interactions, or to maintain interactions at a distance, with persons who do possess that characteristic. Many first-hand accounts describe the rejection and avoidance that are routinely experienced by people with physical disabilities, e.g., "People in the apartment watched me come and go. I didn't know them. They didn't ask about me. I didn't ask about them. I was alone" (Hockenberry, 1995). If a person who is blind is greeted at an academic conference not by name or with the usual introductory questions about professional affiliation or place of residence, but rather with the statement, "Let me know how I can help you," her full individuality has been subsumed by the recognition of her disability (Asch, 2001).

A parallel phenomenon occurs on the part of those individuals who possess a stigmatizing characteristic. In the context of pervasive social disapproval for a fundamental characteristic, it becomes easier sometimes for a person to maintain connectedness within the group of people that share the same characteristic than to be faced with the recurring tasks of self-protection and self-definition that are required in interactions with people who do not share it. Some have described this chosen isolation as "ghettoization" (deMonteflores, 1993) and pointed out that it serves a protective function while also serving to maintain a group's marginal status. Consider this comment from a man with a

visible disability: "I like best to be out of sight of strange people. I envy to be normal like the other fellow" (MacGregor, Abel, Bryt, Lauer, & Weissmann, 1953).

People who are stigmatized may therefore be tentative in social interactions, wondering before each new encounter whether they will be accepted or rejected. "The fear that others can disrespect a person because of something he shows means that he is always insecure in his contact with other people; and this insecurity arises, not from mysterious and somewhat disguised sources as a great deal of our anxiety does, but from something that he knows he cannot fix" (Perry, Gawel, & Gibbon, 1956).

The interactional dynamics are a bit different based on whether the stigma is immediately apparent or not. For persons with an apparent stigma, any initial encounter is tarnished with anxiety about how the other person will judge them. Some people with visible indications of their difference develop strategies to allow others to see them from a distance before initiating an interaction, thus permitting some time for the person to recognize the "mark" and decide how to respond to it. Some people worry that they can never be sure that others will show or tell them what they really think about them, i.e., that they cannot assume authenticity in the relationship. Goffman describes that "while this work of careful disattention is being done, the situation can become tense, uncertain, and ambiguous for all participants, especially the stigmatized one." The stigmatized person is expected to collude with others in acting as if his/her known differences were irrelevant and not requiring attention.

In contrast, when a person's differentness is not immediately apparent, there is also the constant worry of discovery. The task of "information control" takes on tremendous significance. The person has to consider in every instance to whom he/she owes what information, how the information will be transmitted from one social contact to another, and the potential cost of candor in volunteering aspects of information about him-/herself in different social circumstances. By implication, it is important also for the individual to maintain an active memory, an accurate accounting regarding who knows what and which people are guarding which aspects of his/her secret identity. Thus the person's personal identity divides up his/her social world—broadly into those who know and those who don't. The accounting never remains that simple, though, since various people will know different aspects of the person's true identity. Also each person who is entrusted to know some part of the secret may divulge varying parts of it to others, and thus the wider the circle of people to whom he/she has disclosed the stigmatizing information, the less secure the secret becomes. Living with the knowledge that stigmatizing information can be transmitted without the person's knowledge or choice creates a great deal of anxiety and tends to discourage disclosure.

As a result, people with invisible discreditable characteristics must be alert at all times to aspects of social situations that others take for granted. Because ordinary social interactions can become management problems at any moment, constant vigilance is necessary. As a result, people may maintain various levels of distance in their social relationships to assist in this exercise

of information control. For example, "Since my brother's suicide, I am hesitant to make new friends. It is easier to associate with friends who knew me before I took on this new pseudo-identity. It makes me feel vulnerable to criticism by everyone" (personal communication). The unfortunate result of that strategy is that by declining social overtures in order to avoid the obligation to divulge information, they also lose out on the benefits of close relationships.

On a very direct tangible level, stigma limits *everyone's* opportunities. Social networks are constricted between members of the stigmatized group and others. As a result, stigma keeps people from knowing each other–it creates barriers to close relationships, friendships, intimacy. We are all deprived of learning about the unique life stories and life experiences of people who are in some ways unlike ourselves, losing the chance to discover how like us they may actually be.

In addition, stigma also creates uncertainty and some degree of fear. If today we discredit people who have a particular set of characteristics, what assurance does an individual have that at some future time some characteristics she/he possesses will not be singled out for similar disapprobation and discrimination. "If life is made up of various sorts of 'clubs' which only some can fully join, when will it be my turn to be shut out?" (Adrienne Asch, personal communication).

Stigma operates also to lower expectations of members of the stigmatized group. Both social exclusions and efforts at self-protection combine to limit aspirations and socially-sanctioned evidence of success. By justifying discrimination, stigma limits access to opportunities in education, vocational choices, employment, housing, and even travel in both explicit and indirect ways. By extension, it restricts opportunities for economic and social advancement. Lowered expectations and lowered achievement further solidify threatened self-esteem, completing the circle of lost opportunity.

A different response to pervasive stigmatization is sometimes seen among people of stigmatized groups who nevertheless have high aspirations and achieve success in their chosen careers. They may overcompensate for the stigmatization they expect, essentially over-achieving. They may feel that they have to aspire to a kind of perfection and a higher level of achievement than would ordinarily be expected. This phenomenon has been described among professional women, for example, who may hold themselves to an unrealistically high standard of performance in order to show that they can "hold their own" despite pervasive doubts about their capabilities—the "imposter" phenomenon. Stigmatized individuals may feel responsible, in fact, for dispelling negative stereotypes about an entire group of people, for being beyond reproach not only on their own behalf but also as a sort of emissary.

ROOTS OF STIGMATIZATION

Stigmatization is pervasive because it serves multiple purposes. People may stigmatize others to reduce the complexities of understanding them as

multifaceted individuals, to feel better about themselves, to feel better about their groups, to justify their preferential status in society, to validate an important world view, or to defend the exclusion of people who are seen as a threat to the functioning of a social group (Neuberg, Smith, & Asher, 2000). Fundamentally, stigmatizing people who are different from themselves allows people to define themselves as superior. This function operates through the process of downward comparison: comparing oneself to someone less fortunate can increase one's own sense of well-being and thus boost one's self esteem (Wills, 1981). "Stigmatized people are needed in order for many non-stigmatized people to feel good about themselves" (Coleman, 1986). Indeed, people who feel vulnerable as a result of stigmatization sometimes respond to their diminished social position by devaluing people with a different stigmatizing characteristic. For example, a hierarchy exists among some people with disabilities regarding what sort of condition is "worse," and non-heterosexuality is especially strongly maligned among some people of color.

Beneath stigmatization of people who possess certain characteristics is often an irrational fear of contagion—the idea that somehow they could "catch" the stigma. While usually irrational, this fear unconsciously reinforces the maintenance of distance, isolation, and restriction of social discourse between people who do and people who do not possess a particular "discrediting" characteristic. The phenomenon of "secondary" stigma reinforces the fear of stigmatization-by-association.

THE "SPECIAL CASE" OF HOMOSEXUALITY—HOW DOES IT FIT THE GENERAL CATEGORY OF STIGMA AND HOW IS IT DIFFERENT?

Non-heterosexuality is severely stigmatized in most cultures. There are different responses to homosexuality, bisexuality, and transsexuality, but as a group, they all share negative judgments and systematic discrimination. Many people have pondered why this is so. Perhaps it is the threat of something so basic as sexuality being different from what is known and familiar—a challenge to heterosexuals' sense of security about their own sexuality. There is likely also to be for some an element of fear—most tangibly a fear of being seduced by a gay man or woman, or of sexual violence. It is to this basic fear that the term "homophobia" refers. The religious and moral condemnation attached to homosexuality also contribute to the fear. Virulence and aggressive sexuality are strong values held among heterosexual men in both primitive and industrialized societies, but are qualities that are easily threatened. Some authors have suggested that the strength with which homosexuality is disavowed may reflect a need for reassurance that virility is unquestioned. Some evidence points to more powerful stigmatization of male than of female homosexuals. Above all, stigmatization of non-heterosexuality ensures that heterosexual men and women will be seen as dominant and "better" than the stigmatized group.

Whatever the reasons, there can be no doubt of the negative stereotyping ubiquitous in most modern societies about homosexuality and homosexuals.

It is instructive to think about the effects of that phenomenon on children and adults who are gay or lesbian, and on their families. Consider this reflection by a prominent gay man: "It was in sixth grade that I first got labeled 'faggot'. I had done remarkably little to 'earn' the name. I hadn't yet had a boyfriend and I hadn't yet 'come out'. I had made the more fatal mistake of not 'acting like a boy' " (Jennings, 2001). Similar stories are easy to uncover. Attitudes about gender are inextricably bound with attitudes about sexuality, and deviations from cultural norms are punished harshly from an early age. Like other stereotypes, homosexuality is taken to describe a whole person, denying the uniqueness that makes up each individual and the diversity of persons within the broad category.

In many ways homosexuality, or more broadly sexual minority status or non-heterosexuality, shares the general characteristics discussed above of a stigmatizing characteristic that is not immediately apparent. As such, it serves to marginalize people who are gay or lesbian, limits their opportunities and their social networks, and threatens their self-esteem. Because homosexuality is usually not visible, its recognition is under the control of the individual. While that is comforting to some extent, it also means that the individual is faced over and over with the daunting job of assessing the safety of the particular person and context, and finding a way to disclose his/her "secret." Every reader will recognize the judgments involved in deciding which people to tell about one's idiosyncratic quirks, habits, and vulnerabilities. Because of the powerful stigma it arouses, homosexuality presents a particular challenge to disclosure. Because it is easy to "pass," maintaining a secret identity may seem easier than acknowledging one's differentness. It takes an active effort to identify oneself as different from the prevailing expectation, and it is rare to be provided with an invitation to disclose. The psychic energy required by constant vigilance and "information management" results in awkwardness in social interactions and maintenance of interpersonal distance. Some lesbian and gay individuals choose to make their sexual orientation known by wearing a particular lapel pin or style of clothing in order to ease the necessity for continual vigilance and decision-making about disclosure.

The notion of "secondary stigma" or stigma-by-association is also very relevant to understanding the experience of families with a non-heterosexual member. Children whose parents are gay or lesbian are confronted with the requirement to "manage" information before they have any real recognition of its social meanings or potential risks. Similarly, parents may find themselves suddenly discredited when information that they have a gay or lesbian child becomes known. The family's process of coming to terms with a child's "coming out" may be as difficult as the adolescent's own process. The challenge of "information management" is more complicated when various members of a family may have different reactions to and face different risks from disclosure.

Homosexuality is also somewhat different from other stigmatized characteristics. First, sexuality engages high cultural investment, and thus strong judgment is applied to diversity in sexual orientation. Criticism that arises from an ethical and religious stance heightens the strength of stigma against it.

As a result, the stakes are high and it takes considerable courage to risk being known as non-heterosexual. The consequences may be rejection by friends and family, loss of a job and/or employment prospects, violence against oneself or a family member, or restrictions in social opportunities (housing, insurance coverage, education).

Another important difference relates to the family context. Homosexuality is a stigmatizing characteristic that is not generally shared by other members of the family. Race, national/ethnic heritage, religion, even socioeconomic status, are usually shared within the family. Children may grow up knowing that they are discredited in the wider society, but they can feel sure of the support of the family. Not so with homosexuality.

Many people grow up knowing about some stigmatizing characteristic they possess, e.g., a child who is congenitally blind or has a limb deformity. Children may not recognize the characteristic as stigmatizing until adolescence, but they and their families are aware of its presence. Homosexuality is somewhat different. Generally it is not identified until adolescence, or even later, and even then may be recognized only by the individual him/herself and not by others. The adolescent and her/his family must readjust their perceptions of her/his identity in a fundamental way after 14 or 16 or 20 years of different assumptions. Even after an adolescent recognizes his/her own non-heterosexual orientation, he/she cannot assume that others know it as well. Goffman quotes a gay man who says, "When jokes were made about 'queers,' I had to laugh with the rest, and when talk was about women I had to invent conquests of my own. I hated myself at such moments, but there seemed to be nothing else that I could do. My whole life became a lie" (Goffman, 1963).

Is being homosexual a choice or an inborn characteristic? The intensity with which this question is debated stems from the differential stigma that is applied to characteristics that people are thought to choose (alcohol abuse, criminal behavior) and/or might be able to change (smoking, obesity), compared with those which are seen to have developed beyond the individual's control (blindness, epilepsy). If homosexuality is inborn and only becomes evident after five, ten, or fifteen years of life, like diabetes or asthma, some hope that it might stimulate a less powerful judgment.

Can such a distinction be justified? Can we be content in a fair and ethical society to discriminate against a person who *chooses* a certain set of values and behaviors any more than if s/he were *endowed* with them by an accident of genes and life experience? Surely we can make room for diverse choices along with diverse DNA. Furthermore, it is unlikely ever to be possible to separate volitional and innate characteristics in any meaningful way. Undoubtedly genetic factors, uncontrollable environmental influences, and an individual's choices all contribute to people's individuality. Perpetuating the idea that it is remotely possible for important characteristics to be purely volitional or purely predetermined adds to the feelings of confusion, guilt, and shame that stigmatized individuals and their families experience.

Let us consider some specific circumstances that illustrate the pervasive impact of stigma on people of non-heterosexual orientations. (1) A teenage boy

has come to think he might be gay. In order to share even his wondering about that with anyone, he first must determine whom he can trust to protect his secret and not to reject him. Eventually he has to find a way to let others know of his recognition that he possesses a characteristic of which many disapprove. He is likely to have heard many jokes and derogatory comments about gay and lesbian people in school and at home. The risks of "coming out" are enormous and may mitigate its benefits. It is critical for him to find a supportive guide or group who can help him with the process of "coming out" in a way that will be affirming and not destructive.

(2) A lesbian woman is applying to medical school. She has to decide whether to withhold her self-identification as a lesbian prior to acceptance because disapproval of her sexual orientation may limit her chances of admission to the best schools. Once she has been admitted, she must decide how to locate friends who will not disapprove of her sexual orientation, and indeed would like to find some lesbian and gay colleagues. Only if the medical school has a social group for lesbian and gay students can she feel safe as a member of a supportive group of students who are aware of her sexual orientation.

(3) A 15-year- old boy tells his mother that he is gay. She supports him and reassures him that her love for him has not changed with this disclosure, but she enjoins him not to tell his father or sister and not to let his sexual orientation be known at school. They would be devastated, she says, and if his sister's classmates were to find out, they would reject her. The mother is trying to protect her husband and children from secondary stigmatization. In many families, such secrets are also kept from grandparents. Unwittingly, by colluding with the boy to maintain secrecy, she is reinforcing his fear that he is "marked" with some dangerous characteristic that will be destructive to the people he loves and counts on most. At the same time, his mother is renouncing the opportunity for the adolescent and his family members to join a community of support and to work together in confronting social discrimination.

(4) A gay physician is appointed to a faculty position in a new city. He has not disclosed his homosexuality in the past but has chosen to try selectively to do so in the new job. He knows that if patients know that he is gay, he may have difficulty building his practice. He is concerned that the student body also may have difficulty respecting him as their mentor and teacher if they know that he is gay. He must learn the sources of support. Then he must devise a careful strategy for assessing the level of acceptance he thinks he can expect from each of his colleagues and find a time and place to tell them that he is gay, also asking them to assure him that they will not disclose the "secret" to any one else so that it will not interfere with students' or patients' respect for him. Often there are both anticipated and real negative consequences of "coming out" at work. On the other hand, disclosure allows the possibility of integration into the workplace with greater self-confidence and less anxiety.

(5) The lesbian parents of a 5 year old boy have provided a stimulating and nurturing community for him, including a preschool attended by several children whose parents are gay or lesbian. One of the preschool teachers is herself a lesbian, and she has maintained inclusive discussions in her classroom.

The child is about to go to kindergarten in public school. His parents know that there are teachers in the school and a small group of parents who are harsh judges of homosexuality. What will they tell their son regarding how he should describe his family? Can a 5-year-old understand rules of "selective disclosure"? How can they teach him to resist pejorative jokes and comments from classmates and adults? How will they help him understand why he is not invited to certain children's birthday parties?

(6) Parents divorce when the father "comes out" as gay and develops an intimate relationship with a partner, but both parents remain actively involved in their children's lives. Their father attempts to protect his children from the harsh realities of the stigmatization he has experienced and believes that his straightforward and honest acceptance of his sexual orientation and his new family constellation will allow his children to grow up free of stigmatization. His children, on the other hand, may feel trapped. They know that their family is very different from those of their friends, indeed that it is not considered "normal." They may isolate themselves, keeping their father's homosexuality secret out of fear that others will disapprove of them on account of it. In an effort not to hurt their father's feelings, they don't talk about their experience of stigmatization or ask him to help them prevent and cope with it.

RELEVANCE OF THE NOTION OF STIGMA IN HEALTH CARE CONTEXTS

Stigma is a risk factor for mental and physical illness. There is clear evidence from research on racial and other forms of discrimination that the experience of stigmatization is associated with psychological distress and the development of mental health disorders (Fife & Wright, 2000; Kessler, Mickelson, & Williams, 1999; Markowitz, 1998). The repeated documentation of increased rates of anxiety disorders, depression, substance abuse, and suicidal ideation among people of non-heterosexual orientation is consistent with this association.

Considerable evidence has been accumulated that documents the association between psychological distress and physical illness. Although the lines of causality are likely to be complex and not linear, it is reasonable to suppose that the appearance and/or severity of expression of some physical symptoms and syndromes may in some way be related as well to exposure to discriminatory behavior and attitudes. Social stigmas that are attached to particular social groups have been incorporated into the relationships between professionals and patients, the education of health professionals, and the research priorities that guide funding and academic productivity. Systematic inequities in the health care provided to women, immigrants, people of non-dominant races and of non-heterosexual orientation are documented repeatedly.

In addition, societies have long stigmatized people based specifically on the basis of their health status. People with leprosy have been isolated and

scorned for centuries. Current categories of people that are targets of stigma and discrimination include people with AIDS, people with a mental illness, and people with a physical or sensory disability. In the realm of pediatric health care, parents of children who have epilepsy, who have attentional or learning disorders, and who have various other chronic health disorders describe stigmatization and marginalization not only of their children but also of themselves.

Medical students, residents, and practicing physicians who are members of stigmatized groups have had difficulty being accepted as full members of the profession. Women now represent 50% of medical students nationwide, but this development was slow in coming. They continue to be under-represented in positions of authority. The proportion of African-American, Hispanic, and other under-represented minorities in medical school classes in 2001, after a decade of deliberate attempts to attract, recruit, and support them, is still only 11% nationwide. It is hard to know the number of gay and lesbian medical students: until very recently most have chosen not to be formally identified, and they are not recruited as a part of affirmative action efforts.

Medical education itself reflects the same phenomena: limited space in the curriculum of most medical schools and residency programs reflects the value given to the topic under consideration. The same is true for the allocation of research funding. Issues related to women's health, the conditions that affect people of color, and gay/lesbian individuals have traditionally received less attention in education and in research support than issues affecting mainstream culture. Reflections of the stigma of non-heterosexuality in medical education and research are discussed extensively in Chapter 2.

SOLUTIONS?

Stereotypes about stigmatized individuals can be modified. When people overlook the generalizations they have been taught and come to know others as individuals, they begin to dispel the stereotypes on which stigmas are built. One such effort is through structuring of positive intergroup contacts. Perceiving a "marked" person as a complex individual, with many facets and characteristics, decreases the salience of the stigma and permits other more individuated factors to create the basis of a full relationship. "When stigmatized people have essential information or possess needed expertise, we discover that some of their attributes are not so different, and that they are more similar to us than different" (Coleman, 1986). Such personal contacts may also raise people's awareness of the ways in which their behaviors towards various groups of people reflect their underlying—but often unintentional—discriminating attitudes.

Erving Goffman was writing about stigma before the time when a sense of solidarity among people with similar potentially discrediting characteristics resulted in pride and a sense of mastery that now serve to counteract the potential alienation of stigmatization. To some extent, the devaluation of people as a

result of the destructive process of stigmatization only persists if the stigmatized groups accept the negative judgments handed to them. If stigmatized groups do not accept the notion that their differentness is inherently undesirable, they challenge the whole paradigm on which stigmatization is based. This is not the same as "blaming the victim" —to be sure, ethnic pride could not prevent the persecution of the Jews during the Holocaust, nor rid South Africa of apartheid.

Stigma is defined by and empowers the dominant subculture and strips the stigmatized of power. The recognition that the responsibility for being judged inferior does not lie within oneself is important for self-empowerment (Coleman, 1986). Sartre has pointed out that the problem in most oppression lies with the stigmatizer, but that one of the ways in which it exerts its effects is when the stigmatized "buy into" the pernicious views of their oppressors, when "they allow themselves to be poisoned by the stereotype and live in fear that they will correspond to it" (Sartre, 1948).

Modern movements of self-empowerment are based on this principle. Disclosure of hidden characteristics that may be stigmatized—a refusal to "pass"—is central to the transformation of an apparent deficit into a strength and a profound self-affirmation (deMonteflores, 1993). The struggles for equal rights for people of color, for women, for people with physical disabilities, and more recently for gay men and lesbians are about refusing to see oneself and ones peers as victims, about challenging the stereotypes and countering the effects of stigma.

These movements for equality have additional benefits for those who are involved with them. They become much-needed communities of support which promote both individual strength and the ability to take on social and personal advocacy. Activities centered in such a group may help its members resist the effects of negative social stereotypes, and provide a supportive environment which focuses on the particular strengths and valued characteristics of its members, thus protecting self-esteem (Crocker & Major, 1989). School- and community-based youth groups for gay and lesbian youth, the international group PFLAG, and local groups for gay and lesbian parents and their children are examples of groups that serve to enhance self-esteem, mobilize personal and community strength, and work to fight stereotyping and stigmatization of non-heterosexual individuals.

In addition, such supportive groups serve for some individuals with non-apparent "discrediting" characteristics (e.g., gay men and lesbians) as an indirect method of becoming visible. Participation in a youth group for non-heterosexual teenagers, wearing a lapel button proclaiming one's sexual orientation, or marching in a "gay pride" parade may make a subtle statement about the participant's identity. Recent work has documented the similar beneficial effects of involvement with email groups or internet-based communities. It is important, however, not to equate involvement with such activities and groups with a self-definition of identity, as supporters may participate as well in a declaration of solidarity. Gay-Straight Alliances in many high schools and colleges are examples of the value of solidarity.

SUMMARY

Homosexuality is severely stigmatized in most societies. People of non-heterosexual orientation share many of the negative judgments and their consequences that accompany the presence of any discrediting characteristic. People are homogenized under a label that erases their individuality and denies diversity among them. Pervasive criticism threatens their self-esteem and lowers their expectations. Stigma isolates people from one another.

Like other characteristics that are not immediately apparent, people of non-heterosexual orientation are confronted recurrently with the challenge of "information management." They must constantly assess their environment for evidence of risk vs. safety. This vigilance is demeaning and exhausting.

In addition to the commonalities among potentially discrediting characteristics, homosexuality arouses some disapprobation and negative judgment that are unique. It challenges the high investment in modern society on sexuality and gender. Sexuality is already a highly charged area especially for adolescents. It has been imbued with an ethical/religious subtext that serves to deepen the emotional reaction further, hence pervasive heterosexism and homophobia. Homosexuality shows itself slowly and with barely perceptible evidence over the course of childhood, finally allowing the individual to recognize it only after some time and a great deal of experience with stigma. Perhaps most poignantly, homosexuality is fundamentally a lonely stigma, recognized only, at first, by the individual, and shared not even within the family. In subsequent chapters of this book, I will describe some effects of stigma on non-heterosexual youth and adults, and consider some efforts to counteract them.

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2

Homonegativity within Medicine

In India there are butterflies whose folded wings look just like dry leaves. In South Africa there is a plant that is indistinguishable from the stones among which it grows: the stone-copying plant. There are caterpillars that look like branches, moths that look like bark. To remain invisible, the plaice changes color as it moves through sunlit water. What is the color of a ghost?

Anne Michaels, Fugitive Pieces

Physicians and other health care professionals are not exempt from generally-accepted homophobic beliefs and heterosexist attitudes. Continuing personal and institutional efforts are required in order to protect gay men and lesbians from disapproval and attack and to create a social environment that embodies fewer risks. Prevalent prejudicial stereotypes are hurtful directly to patients, students, and colleagues who are gay or lesbian. In addition, because physicians are respected opinion leaders, their attitudes also indirectly perpetuate social stereotypes.

When gay and lesbian physicians risk censure if they disclose their sexual orientation, *everyone* suffers. Not only are they forced to work in an unwelcoming environment, but heterosexual students, patients, and professionals cannot benefit from knowing their experiences and life stories. Gay and lesbian students, patients, and professionals are not provided the benefits of support, teaching, and role-modelling that these physicians could provide. Gay and lesbian physicians need the freedom of an environment free of risk to provide the best care to patients, to be mentors and role models for both gay and non-gay students and patients, and to share their perspectives among their colleagues.

PHYSICIANS' ATTITUDES TOWARD HOMOSEXUALITY

Attitudes of physicians toward homosexuality have changed markedly over the past three decades, probably reflecting changes in general social

attitudes. An informal survey in 1971 of 210 general practitioners and psychiatrists in Great Britain revealed that over two-thirds considered homosexuality to he an "aberrant behavior pattern" (Morris, 1973). Homosexual men and women surveyed in 1979 confirmed that the judgmental attitudes of physicians caused many patients not to disclose their sexual orientation. Their secrecy jeopardized their satisfaction with and the comprehensiveness of their medical care (Dardick & Grady, 1980).

A widely-publicized survey assessed attitudes of members of the San Diego County Medical Society in 1982. The generalizability of the findings is uncertain because only 42.7% of the intended sample responded, and no information is available to clarify differences between respondents and nonrespondents. Nevertheless, the results reveal rather strikingly prevalent negative attitudes. The investigators administered a 20-item attitudinal scale (Larsen, Reed, & Hoffman, 1980; Larsen, Gate, & Reed, 1983), 'Heterosexual Attitudes Toward Homosexuality' (HATH), Table 2.1. Scores on the HATH scale were interpreted to reflect homophobic attitudes among 22.9% of respondents. Women, younger physicians, and those practicing in an academic or public health setting were more likely to report more favorable attitudes towards homosexuality. Physicians differed by their specialty as well: psychiatrists, pediatricians, and internists reported generally more favorable attitudes, while about a third of surgeons, obstetricians, and general/family practitioners gave scores that were interpreted in the "homophobic" range. While the majority of respondents reported "no negative feelings" with regard to treating gay and lesbian patients, 39.4% reported that they were "sometimes or often" uncomfortable in treating a homosexual patient (Mathews, Booth, Turner, & Kessler, 1986). In 1983, about one-third of general practitioners in Great Britain also reported feeling uncomfortable with male homosexuals, considered them a danger to children, and thought that they should not be employed in schools (Bhugra & King, 1989).

Also in the mid-eighties, residents in internal medicine and nurses working on medical units and in an emergency room were found to be "mildly homophobic" on another 21-item questionnaire (Hudson & Ricketts, 1980). Nurses (predominantly women) were reported to be more homophobic than the physicians (mostly men). Unfortunately the published report does not provide much detail about these responses (Douglas, Kalman, & Kalman, 1985). A similar questionnaire administered to medical, nursing, and physiology students also revealed evidence of judgmental attitudes about homosexuality, with medical students reporting more negative attitudes than nursing or physiology students. Higher "homophobia" scores were correlated with lower scores for "empathy" regarding patients with AIDS. Not surprisingly, more knowledge about homosexuality and AIDS was associated with greater empathy (Royse & Birge, 1987).

Family medicine residents and fellows in nine university-affiliated programs in southern California responded to the HATH questionnaire. Almost 20% of male residents and 2.5% of female residents stated that they were uncomfortable with homosexuals, and only 62.4% of respondents scored in

TABLE 2.1. The 'Heterosexual Attitudes Toward Homosexuality' Scale

The 'Heterosexual Attitudes Toward Homosexuality' (HATH) Scale is a validated 20-item paper-and-pencil questionnaire often used to assess respondents' judgmental beliefs about homosexuality. All items use a Likert scale format, with response options 'strongly agree', 'agree', 'neutral', 'disagree', and 'strongly disagree'. Total scores are classified as *homophilic, neutral,* or *homophobic.*

I enjoy the company of homosexuals.
It would be beneficial to society to recognize homosexuality as normal.
Homosexuals should be allowed to work with children.
Homosexuality is immoral.
Homosexuality is a mental disorder.
All homosexual bars should be closed down.
Homosexuals are mistreated in our society.
Homosexuals should be given social equality.
Homosexuals are a viable part of our society.
Homosexuals should have equal opportunity in employment.
There is no reason to restrict the places where homosexuals work.
Homosexuals should be free to date whoever they want.
Homosexuality is a sin.
Homosexuals need psychological treatment.
Homosexuality endangers the institution of the family.
Homosexuals should be accepted completely into our society.
Homosexuals should be barred from the teaching profession.
Those in favor of homosexuality are homosexuals themselves.
There should be no restrictions on homosexuality.
I avoid homosexuals whenever possible.

Scoring: 1: strongly agree
2: agree
3: neutral
4: disagree
5: strongly disagree

Items reversed in scoring: 3,4,5,6,13,14,15,17,18,20
'Homophilic': scores 20–49
'Neutral': scores 50–69
'Homophobic': scores 70–100

the scale's "homophilic" range (Prichard, Dial, Holloway, Mosley, Bale, & Kaplowitz, 1988). A telephone survey of office-based internists, family and general practitioners, and obstetricians in New York City in 1988 yielded substantially the same results. Thirty-six percent agreed with the statement that "homosexual behavior between two men is just plain wrong," and 16% agreed that "male homosexuals should not be allowed to teach school." Only 35% agreed that "it would be beneficial to society to recognize homosexuality as normal." It is important to note also that only 58% stated that they "always" or "usually" take a sexual history on new patients, and only 39% "always" or "usually" ask their male patients about their sexual orientation (Gemson, Colombotos, Elinson, Fordyce, Hynes, & Stoneburner, 1991).

A particularly clever investigator created four vignettes describing two men, one homosexual and one heterosexual, one of each with leukemia and one with AIDS. Each of 119 medical students responded to a set of questions assessing their attitudes about *one* of the vignettes (i.e. about 30 students responded to each of the four separate vignettes). The results were alarming: students revealed highly significant differences in attitudes towards the hypothetical patients with the two different diseases, and—independent of the disease—towards the men according to their sexual orientation. Regardless of which disease was involved, the homosexual patients were viewed as being more responsible for their illness ($p < .005$), more dangerous to others ($p < .05$), and as suffering less pain ($p < .05$) than the heterosexual patients. The students stated that they would be less willing to interact, even in the most casual manner, with the man identified as homosexual than with the man identified as heterosexual ($p < .05$ to $p < .0001$). Furthermore, students ascribed different personality characteristics to the patient portrayed in the vignette when he was identified as homosexual than when labelled as heterosexual. Homosexual patients were described as less "appropriate," more "offensive," less "truthful," less "likable," and "inferior" compared to the heterosexual patients ($p < .01$ to $p < .001$) (Kelly, St. Lawrence, Smith, Hood, & Cook, 1987).

The same authors found similar attitudes among nurses (Kelly, St. Lawrence, Smith, Hood, & Cook, 1988). On the other hand, this study was repeated at a different medical school in a different region just two years later, using the same vignettes and rating scales, and those students revealed far fewer negative attitudes. Still, these students reported their belief that 26% of their teachers and 49.5% of their peers had a "negative attitude" toward homosexuals. Among the students themselves, 10.8% stated that they "strongly dislike and would avoid" interaction with a homosexual man (McGrory, McDowell, & Muskin, 1990).

A survey mailed to a nationally representative random sample of physicians in primary care practice in the U.S. revealed that similar attitudes persisted in 1990. Thirty-five percent of the respondents stated that they "would feel nervous among a group of homosexuals," and 35% also stated that "homosexuality is a threat to many of our basic social institutions" (Gerbert, Maguire, Bleecker, Coates, & McPhee, 1991). About one-third of residents and faculty in psychiatry and family practice in a Canadian medical school gave responses classified as homophobic on the HATH scale (Chaimowitz, 1991). Similarly, a British survey showed that one-half of medical students in 1991 still considered homosexual activity "unacceptable" (Evans, Bingham, Pratt, & Carne, 1993).

Beyond reported *attitudes,* widespread substandard *treatment* of lesbian, gay and bisexual patients was described in a 1994 survey (Schatz & O'Hanlan, 1994). Many gay and lesbian physicians and medical students (67%) reported knowing of gay or lesbian patients who had been denied care or received substandard care, and 88% reported hearing colleagues make disparaging remarks about gay or lesbian patients. Results of this survey are presented in Table 2.2.

A survey of pediatricians in the six New England states in 1996 revealed that 33% felt "uncomfortable" working with a gay or lesbian teenager in their

TABLE 2.2. Experience and Perception of Homophobia*

Type of Discrimination	Percent 'YES' or 'AGREE'
Job-related discrimination	16
Medical school rejection	2
Discouraged or denied residency	11
Denied referrals	16
Denied loan, credit, or insurance	4
Verbal harassment, insults	37
Socially ostracized	37
Other professional discrimination	16
Heard colleagues disparage GLB patients	88
Know of substandard or denied care for GLB patients	67
Observed substandard or denied care for GLB patients	52
Victim of gay-bashing	14
Physicians jeopardize their practice if colleagues know they are GLB	67
Physicians jeopardize their practice if patients know they are GLB	73
Medical concerns of GLB patients may be overlooked if they don't 'come out' to their physician	98
GLB patients risk inferior care if they 'come out' to their physician	64
GLB physicians are accepted as equals	12

* From Schatz B and O'Hanlan K, *Anti-Gay Discrimination in Medicine*, Gay and Lesbian Medical Association, 1994.

practice, and 30% felt "uncomfortable" working with a child whose parent is gay or lesbian. Almost 40% stated that a child would be at risk if her/his parents were lesbian or gay. Not surprisingly (but of some concern) those physicians whose family of origin or current family included a person of non-heterosexual orientation were much more likely to feel comfortable caring for gay or lesbian parents and youth; only 18% felt "uncomfortable" caring for a gay adolescent and 15% for a child whose parents were gay or lesbian (Perrin, 1997).

While the prevailing social discourse with regard to homosexuality has become more accepting, evidence of pervasive homophobia among medical students remains. One-quarter of second-year medical students recently reported believing that homosexuality is immoral and dangerous to the institution of the family and expressed aversion to socializing with homosexuals (Klamen, Grossman, & Kopacz, 1999).

PHYSICIANS' BELIEFS ABOUT LESBIAN AND GAY COLLEAGUES

It is not surprising that physicians' negative attitudes about homosexuality and homosexuals are reflected in their attitudes about gay and lesbian

colleagues. As previously noted, much of the available evidence about physicians' attitudes is based on small questionnaire surveys, often with marginal rates of response. Nevertheless, the consistency of their findings suggests that the overall message transcends the flaws of each individual study. The fact that most gay and lesbian professionals still do not "come out" as gay, lesbian, or bisexual reflects the pervasive risks they encounter (Cabaj & Stein, 1996). Gay men and lesbians differ from other under-represented subgroups within medicine in that their presence is not immediately identifiable. They can choose to shield their sexual orientation from others to avoid stigmatization and discrimination. The cost of this decision may be experienced as isolation and awkwardness in interpersonal relationships and serves also to deprive others of access to their perspectives.

Among members of the San Diego County Medical Society, 29.7% of the respondents to a survey believed that a highly qualified candidate who was homosexual should not be admitted to medical school. Systematic differences existed by physician specialty: 49% of orthopedists were opposed to admission, in contrast to 33.9% of general surgeons, 20.6% of internists, 31.4% of obstetricians, 18.4% of pediatricians, and 9.2% of psychiatrists. Regarding residency training, 45% of respondents stated opposition to homosexuals becoming pediatricians, and 39% stated opposition to their becoming psychiatrists. More than half the respondents in orthopedic surgery, pathology, radiology, and general/family practice were opposed to gay and lesbian physicians training in pediatrics. Least opposed to pediatric training were pediatricians, psychiatrists, and internists. Many physicians also stated that they would discontinue referring their patients to a particular physician if they learned that she/he was homosexual. More than 40% of these physicians said that they would stop referring to a gay or lesbian pediatrician or psychiatrist and 25% to a gay or lesbian surgeon. Almost a third of pediatricians acknowledged that they would not refer to a colleague who they knew to be homosexual (Mathews et al., 1986).

That survey was conducted in 1982. How much has changed? More recently, 10.8% of family medicine residents responded that "a highly qualified homosexual applicant" should not be admitted to medical school, and fewer respondents reported that they would avoid referring a patient to a homosexual consultant. Still, however, the specialists to whom the greatest number of residents were unlikely to refer were pediatricians (29.7%), followed by family practitioners (25.3%) (Prichard et al., 1988). A recent report from Canada documented various forms of continuing harassment of residents, including evidence of homophobia (vanIneveld, Cook, Kane, & King, 1996).

A recent survey in New Mexico provides reason for some optimism, though the low response rate (54%) again makes generalization problematic. Of those practicing physicians who responded, only 4.3% would refuse medical school admission to a gay or lesbian applicant. Still, however, 9% to 10% of respondents would discourage gay and lesbian physicians from seeking a residency in obstetrics/gynecology, urology, or pediatrics, and 11% would not refer a patient to a homosexual pediatrician, urologist, or obstetrician.

Physicians in other specialties garnered somewhat less opposition (Ramos, Tellez, Palley, Umland, & Skipper, 1998).

These destructive attitudes are confirmed by a recent national survey of women physicians 30 to 70 years of age, carried out by the Women Physicians' Health Study. Among the physicians who identified themselves as lesbian, 41% reported harassment based on their sexual orientation in a medical setting. The harassment was reported to have occurred in the context of their medical education (18.2%) and during medical practice (18.5%). Lesbian and heterosexual physicians reported similar rates of *gender-based* sexual harassment, suggesting that the high prevalence of reported harassment regarding sexual orientation is quite specific and does not reflect general over-reporting. Some differences were noted pertaining to their work environment: lesbian physicians working in solo or small group practices were somewhat less likely to have been harassed than those who practiced in other settings, such as a hospital, medical school, or government program (9.7% vs. 27.1%) (Brogan, Frank, Elon, Sivanesan, & O'Hanlan, 1999). General internists in Canada reported a similarly high prevalence of homonegativity. Approximately 40% reported experiencing "homophobic remarks" made by physicians, nurses and other health care workers in their work place (Cook, Griffith, Cohen, Guyatt, & O'Brien, 1995).

A recent series of interviews in Great Britain supports the belief that homonegative attitudes continue to exist within the medical profession, and that this stigma does affect the experience of gay physicians in important ways. Twenty-eight physicians were interviewed: 5 women (3 gay) and 23 men (17 gay). All but one of the physicians reported experiences reflecting homophobia, and the gay physicians gave several examples of the effects of this disapproval on their careers (Rose, 1994). Many respondents reflected on the pervasive assumption that all physicians are heterosexual and reported anti-gay remarks made by colleagues in front of gay medical students and physicians. Those gay and lesbian physicians who had not openly disclosed their homosexuality reported that they had not done so out of fear that it would hinder their career prospects. Some of the gay and lesbian physicians reported being turned down for particular promotions or losing their jobs because of their homosexuality. Both gay and non-gay physicians spoke about the stigma associated with treating patients with AIDS because of the implication that the physicians themselves must be gay. Several of the gay and lesbian physicians described depression and suicidal ideation associated with their concern about whether and how to disclose their homosexuality in professional contexts. All described the need for "impression management" (Goffman, 1959) and the strain that it created in their professional interactions (Goffman, 1963).

Results of an extensive survey of gay and lesbian medical students and physicians who are members of the Gay and Lesbian Medical Association (GLMA) confirm the extent of continuing and widespread anti-gay discrimination within the medical profession. The anonymous survey was mailed to 1311 members of the GLMA and returned by 54% (n=711). Two-thirds of the respondents were male; 17% were medical students, and they were fairly

equally distributed among the regions of the U.S. About half of the practicing physicians were in internal medicine, family medicine, or psychiatry, with the rest distributed in various other specialties. Although significant reporting of discrimination had been expected, its extent was unanticipated (see Figure 2.2). Sixteen percent of the respondents reported being denied referrals; 16% reported being refused medical privileges, fired, or denied employment, educational opportunities or a promotion; and 11% reported being denied or discouraged from applying for a residency position because of their sexual orientation. Even more widespread than these explicit forms of discrimination were experiences of social stigmatization, e.g. 34% of physicians and 51% of medical students reported being subjected to verbal harassment or insulted and/or socially ostracized by their medical colleagues because of their sexual orientation. Overall, 56% of physicians and 67% of medical students reported experiencing *some* form of discrimination and perceived themselves to be unsafe or at least unwelcome in the medical profession (Schatz & O'Hanlan, 1994).

While the medical environment is certainly changing with regard to the inclusion and acceptance of gay and lesbian physicians, medical students continue to report evidence of institutional discrimination and isolation. Third- and fourth-year medical students involved in the American Medical Student Association's standing Committee on Gay, Lesbian and Bisexual People in Medicine reported personal discrimination in their roles as medical students because of their sexual orientation. Examples they cited included receiving an inappropriately low evaluation, being ridiculed, or being singled out as the object of jokes or rumors. Even students who had not disclosed their homosexuality reported negative experiences. For example, one student said, "I had *not one* rotation in which some very negative remark about homosexuality was not made in my presence." A survey of lesbian and gay medical students in Canada also revealed continuing challenges to professional development (Risdon, Cook, & Willms, 2000).

The persistent climate of disapproval about homosexuality is detrimental to the medical education of both homosexual and heterosexual students. While 91% of lesbian and gay students surveyed in 1994 had "come out" to another student in their class, fewer than half had "come out" to their entire class. And, while two-thirds had come out to a faculty member, only 9% had done so prior to their acceptance to the school. Homosexual students may not "come out" for many reasons, e.g. their wish to "fit in" with classmates, the experience of and risk of incurring disparaging remarks by colleagues and faculty members, and the paucity of discussion about gay and lesbian issues in the curriculum (Cabaj & Stein, 1996). Many gay and lesbian medical (and other health professional) students believe that they have to compensate for their "difference" by being beyond any possible imperfection. This effort results in isolation and an atmosphere of considerable added stress.

The perception of homosexuality as a "barrier to professional entry and the pursuit of specialty practice" (Mathews et al., 1986) must surely lead many to the decision that the costs of self-disclosure outweigh the benefits.

Concealing their sexual orientation, though, leaves gay and lesbian students unable to take advantage of whatever formal and informal resources exist in the school or in the wider community and to form mentoring relationships with gay and lesbian faculty (Townsend, Wallick, & Cambre, 1996). It also deprives other students of the benefits of their perspectives and of close relationships with them.

Pervasive experiences of disapproval and discrimination have profound effects on students' decisions about their future careers. For example, 85% of gay and lesbian students believed that certain specialties were less accepting of lesbian and gay physicians than others and stated that they took these differences into consideration when making specialty choices. Psychiatrists were ranked as most supportive and surgeons as least supportive; pediatrics was seen as neither most nor least supportive. One student wrote: "It's tough being interested in the conservative, hard-core specialties, yet knowing I can't live four-plus years in the closet ... how many of us have made career decisions as a result of the profession's homophobia?" (Oriel, Madlon-Kay, Govaker, & Mersy, 1996).

Another survey reports that two-thirds (62%) of gay and lesbian medical students reported hearing anti-gay comments made by a classroom instructor and 42% by a clinical instructor. Seven percent said that their homosexuality had been criticized personally by an instructor. Men and women students reported essentially the same experiences (Townsend et al., 1996). A popular guidebook for medical students regarding residency applications states that "organized medicine still does not feel comfortable accepting gay and lesbian physicians" and cautions applicants that "making it clear to interviewers that you are not heterosexual may doom your application" (Iserson, 1993). Apparently they are correct: 25% of family practice program directors stated that they "might" or "most certainly would" rank gay applicants lower than heterosexuals in the residency match (Oriel et al., 1996).

Explicitly homophobic comments and jokes and implicitly judgmental interactions, such as exclusion from social and professional activities on the basis of homosexuality, create an environment that has been referred to as sexually abusive (Fikar, 1992a). The stigmatization and the climate of fear that is experienced by gay and lesbian physicians obviously have destructive effects on these physicians. They must manage continually the selective disclosure of their true identity in an atmosphere of uncertainty and potential danger, risking their personal relationships and career advancement in countless ways. All professionals find ways to control the impression that others have of them, but consider how much harder this task is for those who are stigmatized. The problem Goffman describes: "to display or not to display, to tell or not to tell, to lie or not to lie," is a daily dilemma for a gay and lesbian physician (Goffman, 1963). Even a physician who is open about his/her homosexuality will encounter repeatedly new circumstances—new colleagues, new patients, new students—in which this dilemma is replayed and the uncertainty, fear, and pain revisited.

In addition to difficulties for these physicians themselves, fear of revealing their homosexuality has unfortunate consequences for others as well. Gay

and lesbian medical students have difficulty identifying faculty advisers and role models at many medical schools because so few faculty members are openly gay. Adolescents struggling with concerns about their own sexual orientation or about that of a relative, teacher, or peer are also deprived of potential positive role models and advisers (Fikar, 1992b). Non-gay medical students are denied the opportunity to know and appreciate fully their gay and lesbian peers and faculty members.

Homonegative attitudes are not unique to medical school environments, but pervade allied health environments as well. Discriminatory policies and inhospitable environments have been documented recently among undergraduate students (Jones, 2000), social workers (Berkman & Zinberg, 1997; Wisniewski & Toomey, 1987), nursing students (Gray, Kramer, Minick, McGehee, Thomas, & Greiner, 1996; Morrissey, 1996; Smith, 1993), midwifery programs, and occupational therapy training programs (Eliason & Raheim, 2000; Jackson, 2000).

PATIENTS' BELIEFS ABOUT GAY AND LESBIAN PHYSICIANS

Reflecting the generalized heterosexism of the popular culture, patients may be uncomfortable with a non-heterosexual physician. A large number of homonegative remarks made by patients have been documented in reference to general internists in Canada, about the same number made by women as by men (Cook et al., 1995). Telephone interviews with 346 randomly-selected adults in a large Canadian city revealed disturbing attitudes regarding homosexual physicians. Respondents stated that they would refuse to see a male (15.1%) or a female (9.3%) homosexual physician. This response was more common among older than younger respondents, as well as among men. Over half gave the reason that she/he believed that a gay or lesbian physician would be less competent. Other reasons included fear of being sexually harassed or contracting a disease, and simply 'feeling uncomfortable' with homosexuals (Druzin, Shrier, Yacowar, & Rossignol, 1998).

MEDICAL EDUCATION

Teaching about homosexuality in medical schools and residency training is important to ensure optimal health care for gay men and lesbians. Physicians need (1) adequate and accurate information about the health risks and needs of gay men and lesbians, (2) to know the best ways to learn about and to assist their non-heterosexual patients, and (3) to confront the personal, institutional, and social heterosexism and homophobia that isolates people with a non-heterosexual orientation. In addition, it is critically important that gay and lesbian medical students and residents be able to assume that their learning environment is supportive and accepting and will provide them the same opportunities as it provides non-gay students/residents. Recent publications

indicate that education about homosexuality in medical education at all levels continues to be quite limited in scope and amount (Kelly & Langsang, 1999; Sue-Sun-Yom, 1999; Vaias, 1994; Wallick, Cambre, & Townsend, 1992). The limited amount of teaching about homosexuality in medical schools and in residency not only reflects but also reinforces the continuing discomfort and enforced invisibility of individuals of non-heterosexual orientations.

A survey of U.S. medical schools a decade ago described that the average total amount of time devoted to homosexuality was 3.5 hours. The subject was generally included in the context of preclinical courses on sexuality and/or in discussions about HIV/AIDS (Wallick, Cambre, & Townsend, 1993). While of historical interest, the relegation of issues about homosexuality to courses about HIV/AIDS no longer has a substantive basis and perpetuates the stereotypes of deviance and danger often associated with homosexuality. These health conditions are now seen with similar prevalence independent of sexual orientation, and there are few if any medical differences regarding HIV infection in gay and heterosexual populations (Ryan & Futterman, 1997).

More recently, a survey of family medicine training directors described little change in medical student curricula about homosexuality. About half of the training directors were aware of *no* education about homosexuality during the four years of medical school. Those who knew of gay and lesbian issues in the medical school curriculum reported an average of 2.5 hours of instruction. Education about gay and lesbian issues generally was embedded in the preclinical curricula about medical ethics or human sexuality. This report documents the continuing paucity of opportunities for non-gay medical students to learn about issues of concern to their gay and lesbian patients and colleagues, and to dispel the stereotypes maintained by lack of information and minimal contact (Tesar & Rovi, 1998). The intellectual growth of *all* students is diminished by this persistent lack of discourse on the topic of homosexuality.

In addition to the small amount of curricular attention, a national survey of U.S. medical schools in 1990 revealed limited support services for gay and lesbian students within U.S. medical schools and their communities (Townsend, Wallick, & Cambre, 1991). A follow-up survey four years later showed important improvements: two-thirds of the medical students surveyed knew of a faculty member with whom they could discuss gay and lesbian issues and concerns, though few of these schools had a designated person charged with this responsibility. In addition, 70% reported the presence of a support group for gay and lesbian students at their school (Townsend et al., 1996). Such explicit support services may be even more important for gay and lesbian students than for students of other minorities. Gay and lesbian students may be relatively invisible and often cannot assume recognition or support even from their family and friends. They have difficult decisions to make repeatedly regarding disclosing their sexual orientation in various contexts.

Little is known about how and when issues related to homosexuality are taught in the context of *residency* training. The inclusion of gay and lesbian

issues in the context of adult (Stein, 1994; Townsend, Wallick, & Cambre, 1995) and child psychiatry training (Townsend, Wallick, Pleak, & Cambre, 1997) appears to be increasing. Of the child and adolescent psychiatry training directors who responded to a survey, 95% reported that the topic of homosexuality was addressed in the regular residency curriculum. Relevant topics were reported to be covered most often in case conferences and in the context of a course in child development or in child psychopathology. In general psychiatry programs, information about homosexuality was usually presented in a Grand Rounds format. The vast majority of training programs report inclusion in their curricula of topics related to homosexuality, though not necessarily as a predictable and systematic part of a curriculum offered to every resident. In many training programs, topics for case conferences and Grand Rounds presentations are dependent on the interests of a particular individual and/or the patients currently being cared for in the institution. Furthermore, only 66% of training directors responded to the survey, leading to some question as to the generalizability of the reports.

Residency program directors in pediatrics also responded to a survey regarding the extent and methods used in teaching issues about homosexuality to residents. Despite the obvious response bias introduced by an interest in "political correctness," only 54.5% of programs indicated that their program included education of residents about medical care of gay and lesbian youth. Of these, the majority of the education (81%) was said to take place in the context of adolescent medicine rotations, with the majority occurring by way of conferences and Grand Rounds presentations. Only 61% of program directors reported being aware of the presence of community resources for gay and lesbian youths (Kelly & Langsang, 1999).

EFFECTS OF HOMONEGATIVITY ON MEDICAL CARE

Damage done by the persistent heterosexism and homophobia of too large a minority of the medical profession includes evidence that gay men and lesbians experience discrimination in health services (Kass, Faden, Fox, & Dudley, 1992) and that they are reluctant to disclose their sexual orientation to their physicians. In one study, 67–72% of lesbians said that they had withheld information about their sexual behavior from their health care provider because they feared that it would negatively affect their treatment (Johnson, Guenther, Laube, & Keettel, 1981). In another study, 27% of the gay and lesbian respondents felt that a health professional had been prejudiced against homosexual persons, and only 49% had told their health provider about their sexual orientation (Dardick & Grady, 1980). Lesbian patients repeatedly document fear of disclosure and their resulting decision not to disclose their sexual orientation to their physician (Bradford, Ryan, & Rothblum, 1994; Cochran & Mays, 1988; Glascock, 1981; Hitchcock & Wilson, 1992). In one study, lesbian patients acknowledged hesitancy to return for follow-up care because of their perceptions and expectations of disrespectful care (Stevens & Hall, 1988, 1990).

In contrast, a survey of gay and lesbian parents found that 77% had described their sexual orientation and family constellation to their child's primary care provider (Perrin & Kulkin, 1996).

Even physicians, members of the Gay and Lesbian Medical Association, who completed an extensive questionnaire reported their belief that while it is medically important for patients to inform their physicians of their sexual orientation, patients risk receiving substandard care by doing so (Schatz & O'Hanlan, 1994). Gay male adolescents who believe that their physicians may be prejudiced against them are understandably more reluctant to confide in them about sexually risky behaviors and thereby forego appropriate screening and care for sexually-transmitted infections (Rawitscher, Saltz, & Friedman, 1996). The hesitancy of gay men and lesbians to obtain regular medical care and/or to disclose their sexual orientation to their physician results from both the perception of negative stereotyping and internalized homophobia. Their reluctance to disclose results in their not having the benefits of regular physical examinations and screening procedures recommended for all adults. They miss as well the opportunity afforded by regular medical supervision for advice and counseling intended to reduce the incidence of disease and disability.

Another direct medical consequence of heterosexism and homonegativity is the paucity of research carried out on the health care concerns of gay men and lesbians (Skelton, 1994). For example, the risk of transmission of human papilloma virus and subsequent cervical dysplasia in lesbians has only recently been described. While sometimes assumed to be at no such risk, transmission of HPV has been shown to occur during lesbian sexual activity (Marrazzo, Koutsky, Kiviat, Kuypers, & Stine, 2001; O'Hanlan & Crum, 1996), and furthermore over 75% of lesbians have had at least one sexual experience with men (Bradford et al., 1994). Partly as a result of the assumption that lesbian women are not at risk for cervical dysplasia, many do not get regular pap smears, or get them less frequently than do heterosexual women (Bradford et al., 1994; Johnson, Smith, & Guenther, 1987; Marrazzo, et al., 2001).

Among gay men, the risk of anorectal carcinoma is 25–50% times higher than that for heterosexual men (Palefsky, 1995), but there are no formal guidelines for screening gay men for precursor lesions. Similarly, few data exist to guide the development of screening guidelines for breast cancer among lesbian women. Nulliparity is far more common among lesbian than among non-gay women and is a known risk factor for endometrial, breast, colon, and ovarian cancers (Holleb, Fink, & Murphy, 1991). Nevertheless, 25% of lesbians over 40 in one survey had never had a mammogram (Bradford et al., 1994). The epidemiology of heart disease, cancer, and other common health conditions among gay men and lesbians is not known.

A review of the CRISP database that catalogs all NIH grants revealed that only 47 grants were awarded between 1972 and 2001 that focus on homosexuality or transsexuality. Of these, only a small minority address health issues for adolescents and young adults other than AIDS.

SUGGESTED IMPROVEMENTS

Heterosexism and homophobia are still ubiquitous in modern society despite increasing awareness and tolerance for diversity of all sorts. Some attention has begun to be focused on efforts to combat its presence in the contexts of medical care and education. Several important statements of policy are worth noting. In 1973, the American Psychiatric Association (APA) issued a landmark position paper stating that homosexuality would no longer be considered to represent a pathologic condition. It called on governments at all levels to include homosexual persons in civil rights protections and to repeal all legislation that discriminates against homosexuals (American Psychiatric Association, 1974). The APA issued another policy statement in 1993 stating that "whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, the APA calls on all international health organizations, psychiatric organizations, and individual psychiatrists to do all that is possible to decrease the stigma related to homosexuality wherever and whenever it may occur" (American Psychiatric Association, 1993).

In 1992, the American Medical Women's Association published a policy statement supporting full rights of housing, employment, marriage, child custody and adoption independent of sexual orientation and calling for an end to discriminatory legal codes (American Medical Women's Association, 1993). After considerable debate, the American Medical Association (AMA) voted to include "sexual orientation" in its non-discrimination statement in 1993. The next year, the AMA went further and called for physicians' "non-judgmental recognition of sexual orientation and behavior" and committed itself to take "a leadership role in educating physicians on the current state of research and knowledge about homosexuality—which should start in medical school and be a part of continuing medical education" (American Medical Association, 1996). However, the AMA's Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education have not yet incorporated the proposed guidelines into their accreditation standards nor mandated that admissions decisions not discriminate against lesbian and gay applicants (Schneider & Levin, 1999; Tinmouth & Hamwi, 1994).

The American Academy of Pediatrics published a policy statement in 1993 encouraging pediatricians to address the health needs of gay and lesbian youth and their parents (American Academy of Pediatrics, 1993). This statement is in revision and will reassert the responsibility of pediatricians to be knowledgeable about the special risks and needs of non-heterosexual adolescents. The statement describes the need to organize pediatric clinical procedures in a way that encourages open discourse with *all* adolescents about the range of safe and responsible sexuality and to provide comprehensive and sensitive care to all adolescents and their families. The American Academy of Family Physicians and the American Society of Internal Medicine have similarly urged their members to work towards equal treatment of patients and physicians independent of sexual orientation (Schneider & Levin, 1999).

Education about homosexuality at all levels is an important part of an overall effort to improve knowledge and decrease stigmatizing attitudes. In medical schools, the needs of homosexual individuals could be addressed in a number of concrete ways. (1) Lectures and clinical case studies throughout the curriculum should include discussions of the range of sexual orientations and sexual behavior. (2) The curriculum should describe the special health and mental health risks and needs of gay and lesbian adolescents and adults. (3) Medical schools should recognize that gay and lesbian students and faculty members are members of an "under-represented minority." Their contributions should be recruited to enrich the diversity of the learning environment. (4) Gay and lesbian faculty members should be encouraged to make themselves available as role models and advisers for patients, students, and residents. (5) An explicit administrative position and/or support group should be developed to serve as a source of advocacy and guidance to facilitate the personal and professional growth of students and faculty members (Townsend, 1998).

Teaching about homosexuality in medical schools and residency programs should be organized around a literature-based curriculum encompassing the diversity of sexual orientation. Such teaching should occur not only in the context of courses about human sexuality or human development, nor only in departments of psychiatry, but throughout the curriculum as appropriate to address specific issues concerning lesbian and gay health risks and needs. Didactic presentations should be combined with discussions in both pre-clinical and clinical components of medical school, as well as during all clinical residency training programs. The pre-clinical and clinical years should include instruction and modeling regarding how to conduct a sensitive and thorough sexual history that includes appropriate ways to ask about sexual orientation and behavior. Clinical work in pediatrics, adolescent medicine, obstetrics/gynecology, endocrinology, genetics, infectious disease, and psychiatry provides abundant opportunities to include discussions of the special circumstances and needs of homosexual patients.

Some strategies for innovations in medical training have been described (Lock, 1998). A curriculum in its first year of implementation at the University of Massachusetts includes lectures, instruction in interviewing, and classroom discussions during the third-year clerkships in family medicine, internal medicine, psychiatry, obstetrics-gynecology, and pediatrics (Sack & Perrin, 2000; Sack, Perrin, & Drabant, 2001). A second-year curriculum has also met with some success (Muller & White, 1997).

Scattered reports document the power of individual actions. At the Louisiana State University, the efforts of a few faculty members have created a formal office responsible for counseling gay and lesbian students (Wallick, 1997). At Stanford University, the efforts of a few committed faculty members have established domestic partnership benefits (O'Hanlan, 1999). Less tangible benefits have been described by several individual students who felt courageous enough to come out in medical school (Goldfarb, 1997; Nguyen, 1999) and have learned the value of self-disclosure in deepening communications with colleagues and patients.

In the past several years, a number of institutional programs have been developed to support gay land lesbian medical students and to counteract the alarmingly hostile climate that has been documented above. Programs described have generally consisted of classroom lectures and/or panel discussions. Class-wide presentations have been made, sometimes by gay and/or lesbian physicians about their lives and about handling sexual issues in their offices, and sometimes by a gay or lesbian adolescent and/or parent. Most include a small group discussion format following the formal presentations. Even brief interactions with gay and lesbian individuals have been shown to diminish fear and distrust (Lance, 1987). Using a variety of attitude scales (Hudson & Ricketts, 1980; Larsen et al., 1980; Morrison, Parriag, & Morrison, 1999), evaluation of these programs reveal that homonegative attitudes generally decrease immediately afterwards, though some report a discouraging return of some negative attitudes by the end of the third year (Wallick, Cambre, & Townsend, 1993, 1995).

In addition to providing peer support, gay and lesbian students increasingly are active in educating their heterosexual colleagues about homosexuality. Several students have written essays in the *Journal of the American Medical Association* about gay and lesbian concerns. At Temple University Medical School, members of the group, "Lesbian, Gay, and Bisexual People in Medicine," wrote and distributed a resource guide. This booklet describes lesbian and gay services in the region and provides instruction to students about providing sensitive and informed health care to lesbian and gay patients. The booklet is distributed to all incoming students and residents, as well as to the faculty (Temple University, 1992). Suggestions for more extensive programmatic interventions are addressed further in Chapter 6.

SUMMARY

Physicians and other health care professionals have made strides in overcoming pervasive homonegative attitudes, but there continues to be room for improvement. Negative attitudes towards homosexuality affect our relationships with our colleagues, with our students, and with our patients. They limit our power to make much-needed changes in our offices, hospitals, educational institutions and communities. Discounting or minimizing the unique qualities and the unique needs of gay men and lesbians and their parents and their children keeps them from participating fully in the health care enterprise and perpetuates their isolation.

A retiring chairperson of internal medicine said recently that he had two regrets about his tenure as chair. He said he was sorry that his department had not sufficiently improved the care of patients at the local VA hospital and that they had neglected the medical needs of gay people: "It wasn't that we thought ill of gays, we just didn't think of them at all (Townsend et al., 1997). That is what stigmatization of some of us does to all of us.

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3

Developmental Considerations

You can be anybody you want to be;
You can love whomever you will.
You can travel any country where your heart leads
And know I will love you still.
You can live by yourself; you can gather friends around;
you can choose one special one.
And the only measure of your words and your deeds
Will be the love you leave behind when you're done

Fred Small, singer-songwriter

THE DEVELOPMENT OF CHILDREN'S DEFINITIONS OF GENDER

Gender is a category made up of many intertwining levels. Physiology defines the most fundamental level, designating people as male or female on the basis of their observable sexual anatomy, but every society surrounds the basic physiology with a system of social rules and customs concerning what males and females are supposed to be and do. As children learn to master and internalize this system, they learn to discriminate and label themselves and others on the basis of sex, to recognize attributes, attitudes and behaviors that are typical of and considered appropriate for each sex, and how to do what is seen as appropriate and avoid what is not. In addition, gender is infused with affect to an extent that few other domains can rival, making it a remarkably salient parameter of social categorization for the young child. This process by which children come to understand the social ramifications of their sex is called gender-role development.

Despite important social changes, expectations for the childhood behavior and adult aspirations of boys and of girls have changed less than one might have anticipated from the rigidity of 50 years ago. Traditionally independence, competitiveness, self-confidence, strength, and dominance have been considered masculine traits. Gentleness, helpfulness, kindness, empathy, appreciativeness,

and sentimentality have been feminine traits. A person was either masculine or feminine: if you were strong, you could not also be sensitive; real men don't cry. Current beliefs allow for somewhat more flexibility, acknowledging that the qualities labelled as typically masculine and feminine exist to some extent in people of both sexes. It has become clear that both sexes have the potential for the full range of human behavior and emotions. In addition, not all men are good at sports; not all are as assertive as others; not all women are comfortable as full-time nurturers. Girls who are encouraged to be passive limit their opportunities, just as men who are rewarded only for their competitiveness restrict the possibilities available to them.

The term "androgyny" has come to be used in connection with efforts at increasing the flexibility of conceptions of appropriate behavior and attitudes. Androgynous people are nurturing as well as autonomous and are neither unemotional nor passive. They are more flexible in their gender roles, displaying the best qualities of both traditionally male and traditionally female stereotypes.

Children learn about gender very early. Cognitive developmental theories have emphasized the regularities in children's understanding of gender and have developed a stage theory of gender-role development. Kohlberg (1966) emphasized the unfolding maturational process by which gender development takes place. He emphasized the sequence of identifying one's own sex (gender identity), of understanding that sex remains stable over time (gender stability), and of understanding that sex remains constant despite perceptual changes (gender constancy).

Empirical data confirm that there is a consistent sequence in the development of children's understanding of these concepts (Fagot, 1985; Marcus & Overton, 1978). Most 2-year-olds know whether they are boys or girls and can identify strangers as "mommies" or "daddies." By the age of 3, children know that daddy has a penis and that mommy has breasts. They consistently apply gender labels, referring to boys, brothers, and policemen as "he," and to girls, sisters, and teachers as "she." They know that blocks, hammers, trucks, and wrestling are for males, while pots and pans, dolls, and aprons are for females, and they generally avoid playing with toys associated with the other gender. On the other hand, preschool children may not be certain that gender is a permanent attribute (Marcus & Overton, 1978). Until 4 or 5 years of age, children may believe that girls could become boys if they acted or dressed like them or cut their hair short (Huston, 1983). This uncertainty about gender reflects the salience of appearances at this age (DeVries, 1979; Thorne, 1986; 1993).

By 4 or 5, children have learned a host of social stereotypes about how boys and girls are meant to behave, believing that girls are more likely than boys to clean the house and to talk a lot and that boys are more likely than girls to mow the lawn and to hit other people (Connor & Serbin, 1977; Paley, 1984). They also classify personal characteristics, identifying gentle, empathic adults as women and strong and robust characters as men (Slaby & Frey, 1975). Young children also develop stereotypes regarding adult roles and careers. In their play, nurses, teachers, and secretaries are girls, while doctors, police officers, fire fighters, truck drivers, and super heroes are boys.

These stereotypes have remained in place over the last two decades despite children's very different experiences. Far more of them have mothers who are working at least part time, many at professional jobs, many in traditionally male careers. Nevertheless, by the time they enter school at the age of 5, most children express stereotypic ideas of what each sex should do, wear, or feel, and react approvingly or disapprovingly toward each other, according to their choice of sex-appropriate toys and play patterns. The boy who wants to help the girls dress the dolls, or the girl who wants to be one of the space warriors, is likely to be soundly criticized by his or her friends (Roopnarine, 1984). Social rules regarding the patterns of thinking and behavior that are appropriate for girls and for boys are pervasive and strongly reinforced by television, books, and the expectations of both adults and children. Children learn their sex and its expectations early and recognize that it is perilous to engage in behaviors earmarked for the other sex. Those rare children who insist on gender-atypical behaviors and choices in spite of these strong cultural forces surely are expressing a strong central attribute of their personal makeup.

Parents can encourage boys and girls to enjoy both dramatic and competitive play, both stuffed animals and trucks, to be both effective leaders and cheerful followers, and to imagine a broad range of careers previously restricted primarily to one gender. It may be particularly important to encourage girls to assert themselves and boys to be nurturant, though difficult to counter the pervasive assumptions children experience regarding gender differences in the adult world (Bem, 1985, 1989).

When parents have had concerns about boys who seem to prefer female-identified activities, or girls who prefer typically male activities, pediatricians generally have reassured them about these preferences. They have been interpreted as evidence of their children's greater-than-average flexibility and seem to be consistent with typical child development and adult functioning. We have hoped that flexibility in gender-role development might lead slowly to breakdown of rigid gender stereotypes that restrict children's and adults' options. The implicit or explicit concern of parents that these typical play preferences might reflect or predict adult homosexuality have frequently been dismissed in our effort to dispel stereotypes and promote the acceptance of androgyny.

GENDER IDENTITY DISORDER

Description of the Syndrome

In our eagerness to encourage androgyny and increased flexibility in gender-role development, pediatricians may have overlooked a critical distinction. Fixed behaviors and preferences that consistently are opposite to social and parental expectations are no more flexible than those that conform to social norms. Some boys *consistently* choose dolls over trucks and housekeeping tasks over sports, avoid aggressive play, take typically female parts in dramatic play, and

adore feminine heroes (such as Snow White and Cinderella). They may draw pictures of themselves with long hair and/or wearing a dress and may state that they wish to be a girl. They often choose girls as preferred playmates. Their birthday wish may be for a Barbie doll with all the trappings. They choose—and may insist on—feminine clothing and makeup. Many are gifted in art, music, dance, and dramatic endeavors. Similarly, some girls prefer aggressive play, contact sports, and boys as playmates. They may dislike or refuse to wear dresses, idolize male superheroes, and state that they wish to be boys.

These children do not exhibit flexibility or androgyny; they exhibit instead rigidly stereotypical behavior marked by its disparity from their anatomic sex. A boy who insists on wearing makeup and women's clothing and says that he wishes he were a girl is demonstrating behavior very different from the enjoyment children of both sexes get from exploring a trunk of discarded women's clothing and taking various different roles in dramatic play (Zucker, Bradley, Kuksis, et al., 1999).

The label of "Gender Identity Disorder of childhood" (GID) is applied to children who feel dissonant with their assigned anatomic gender and display gender dysphoria (Zucker & Green, 1992). The current diagnostic criteria for this syndrome are presented in Table 3.1.

While GID exists in children of both sexes (Zucker & Bradley, 1995), health professionals see fewer girls than boys with GID for several reasons. *First,* feminine characteristics may be seen by young children as more attractive than maleness in our culture. Most of the nurturing adults in the lives of young children are women. Mothers continue to be more available than fathers and provide more day-to-day care and nurturance. Child care workers and preschool teachers are mostly women, as are elementary school teachers. Thus, young children identify being a girl and a woman with nurturing, safety, and warmth. *In addition,* modern society allows greater latitude for appropriate behavior to girls than to boys. It is far more acceptable to be a "tomboy" than to be a "sissy." In the age of socially-sanctioned feminism, girls can more readily aspire to be engineers, lawyers, and even construction workers than can boys aim to become nurses or elementary school teachers. Boys are given more negative feedback when they engage in opposite-sex play behavior than are girls (Fagot, 1977, 1989). Because men continue to be dominant in social status, both at home and at work, it is seen as more normative for a girl to prefer to be like them than for a boy to aspire to more feminine characteristics. Therefore a boy with "girlish" behavior is likely to be less well tolerated and more quickly referred than is a girl who is seen as a tomboy.

The onset of the behavioral pattern described as GID typically occurs during the preschool period, often even before 2 years of age (Zucker & Bradley, 1995). Clinical referral typically occurs once parents believe that their child's preferences are no longer a transient "phase," or when the behavior begins to be noticeable to friends and neighbors and becomes a source of some embarrassment to the family. In addition, while preferred relationships with children of both sexes are tolerated by preschool peers, social relationships may deteriorate

TABLE 3.1. Gender Identity Disorder DSM-IV Criteria

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) Repeatedly stated desire to be, or insistence that he or she is, the other sex.
(2) In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
(3) Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
(4) Intense desire to participate in the stereotypical games and pastimes of the other sex.
(5) Strong preference for playmates of the other sex.

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

and

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

and

C. The disturbance is not concurrent with a physical inter-sex condition.

and

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

in second or third grade as children's patterns of "sex segregation" leave atypical children isolated.

Occasionally children may develop the characteristics of GID in the face of a specific developmental challenge, such as the birth of a new baby of the opposite sex, or an experience of rejection or ostracism by same-sex peers. Under these circumstances the behaviors generally are transient.

The long-term trajectory of psychosexual development in these children is of great interest. Longitudinal data suggest that about two-thirds of boys with GID will become gay men, that another 10% will become transgendered and may request sex reassignment through surgery or hormones, and that the remaining quarter will become heterosexual men (Green, 1987; Zucker & Bradley, 1995). It has not been possible to predict which boys will take which course. No long-term data exist about girls with GID. Retrospective studies confirm that many, although not all, homosexual men recall "atypical" childhood play and playmate preferences and recall feelings of being "different" and marginalized, though most would not have met formal criteria for GID (Bailey, Miller, & Willerman, 1993; Bailey & Zucker, 1995).

Is GID Really a *Disorder*?

In 1973 the American Psychiatric Association removed "homosexuality" from its classification of mental disorders. Adult homosexuality is the most common adult psychosexual outcome for children followed prospectively with the diagnosis of GID (Green, 1987; Zucker & Bradley, 1995). Many authors consider the behaviors typical of children with GID to be the immature expression of homosexuality (Zuger, 1984). One might wonder then why children who appear to be "prehomosexual" should deserve a DSM diagnosis early in their lives, but lose it when they become adults (Bem, 1993; Fagot, 1992; Green, 1987; Harry, 1982; Zuger, 1988, 1989). Indeed, the significance of the syndrome labeled "Gender Identity Disorder" has been challenged.

Inherent in defining a cluster of identified behaviors as a "disorder" is the presence of distress, disability, or disadvantage (Spitzer & Endicott, 1978). It is important to consider first whether the characteristics of GID are associated with distress, and secondarily whether such distress is intrinsic to the *symptom cluster* itself or is created by the child's *social environment.* If the latter, could a change in the social environment alleviate the distress—and would this then make the symptom cluster no longer a legitimate "disorder"? Like contemporary theories of disability and of race, perhaps what constitutes a disorder is largely socially constructed (Asch, 2001).

Many would argue that preschool children with atypical play and playmate preferences become distressed only when they are told that their preferences are unacceptable. There is no intrinsic disadvantage caused to a boy by wearing dresses and make-up, nor to a girl with short hair competing in contact sports. The disadvantage and distress result from parental censure and the social ostracism of family members and peers (Green, 1974; Rekers, 1977, 1985). Others would argue, on the other hand, that it is some degree of intrinsic pathology within the child and/or in the family that results in the syndrome described as GID (Coates & Person, 1985). These chicken-and-egg issues are not unique to this particular cluster of symptoms. While most psychiatric diagnoses are based on subjective distress and are presumed to reside "in the person," some may include in their etiology a conflict with social rules of the external world.

Empirically, many children with GID do demonstrate some discomfort and exhibit various behavioral problems. Boys seen in a referral center for GID were found to have significantly higher scores on both externalizing and internalizing subscales of the Child Behavior Checklist than both the standardization sample and a comparison group of these boys' siblings, as reported by their parents and teachers (Zucker & Bradley, 1995). Internalizing disorders were reported somewhat more commonly than externalizing symptoms. Of interest and potential concern is that 6- to 11-year-old boys demonstrated more behavioral distress than did boys aged 4 and 5 (Coates & Person, 1985; Coates & Wolfe, 1995; Rekers & Morey, 1989, 1990; Sreenivasan, 1985; Zucker & Bradley, 1995). This finding suggests that it is when these boys begin to participate in the broader social context of school and develop a wider network of peers that their "differentness" becomes an increasingly important risk factor to their well-being.

Although less is known about girls with GID than about boys, the available data parallel what is known about boys. Parents of girls with GID reported both internalizing and externalizing problems on the Child Behavior Checklist (Zucker & Bradley 1995). Overall their scores were significantly higher than either the instrument's norms or the comparison sibling sample—but *this was true only for the older girls.* Girls aged 4 and 5 were indistinguishable from the normal control groups on all subscales, while girls over 6 years of age displayed more of both internalizing and externalizing symptomatology. Again, it seems that the distress associated with the behavior pattern of GID stems more from the reactions of peers and adults in the child's environment than from an intrinsic source.

Girls and boys with atypical play and playmate preferences confront stigma from peers and adults. They are isolated and teased. Their parents too face stigmatization and may feel embarrassed, conflicted, and insecure. Their concern may lead to critical and punitive responses. Emotional and behavioral symptoms are likely to be a reflection of this distress rather than an intrinsic phenomenon.

Practical Clinical Implications

The constellation of symptoms that constitute GID is at the extreme end of a continuum. Many boys enjoy playing with dolls and prefer arts and crafts activities to contact sports. Many girls are "tomboys" and eschew feminine dress and domestic activities. It is the fixed and inflexible focus on choices typical of children of the alternate gender that underlie the criteria for GID.

The practical questions asked by the parents of these children are impossible to answer—which of these children will become lesbian/gay? How can we be the best parents we can be for this child? Should we allow him to play with dolls and use make-up inside the house, but not when he goes outside or to school? Should we join in his/her preferences or indicate our dislike/disapproval of them? How much can we—and should we try to—influence her/his adult sexual orientation? The response to such questions will always depend

on the particular circumstances of the child, the family, and the community they live in.

No evidence to date suggests that any actions during childhood alter the developmental path toward a particular sexual orientation in adulthood. Parents of a child with GID, and the professionals to whom they look for advice in parenting, face considerable uncertainty with regard to helpful action. Some principles seem clear. It is legitimate (1) to help children feel more secure about their gender identity as boys or girls, perhaps preventing adult transgenderism; (2) to diminish as much as possible peer ostracism and social isolation; and (3) to treat evidence of associated behavioral/emotional distress. Attempts to alter the early developmental pathway towards a homosexual or a heterosexual orientation are neither ethical nor likely to be effective.

The best advice for parents is what it always is—to support their children, to foster their strengths, and to model desired behavior. All children thrive when they have strong and nurturant relationships with each of their parents. In the press of increasingly busy and complex lives, parents may meet their children's concrete needs for nutrition, daily care, and shelter but inadvertently fall short on meeting their emotional needs. Parents who are concerned about evidence of distress in their children, be it with regard to gender-based preferences or other signs of distress, should be encouraged to focus more on the child's needs for intimate connection with each parent. One suggestion is to schedule a predictable one-on-one "date" for the child with each parent once or twice a week (sometimes dubbed "alone time"). Each parent should find two or three activities she or he enjoys doing with the child and ensure that some time each week is devoted reliably to these activities. If one parent finds this task more difficult than the other, she/he may need explicit suggestions and support to introduce these changes. Helping both parents to focus on finding ways to build intimate connections with their child can go a long way to strengthening both these critical relationships and the child's sense of connectedness and self-esteem. The positive and nurturing qualities of both parents, and their contentment with their own gender roles, should be made evident to their children.

Parents often wonder if they should support their child's gender-atypical preferences or forbid them, or perhaps enforce rules defining the location and context of their expression. For example, what should they tell his grandparents if their 4-year-old son wants nothing other than a new Barbie doll for his birthday? Should they buy him make-up, or allow him to use his mother's? Should they force their 5-year-old daughter to wear a dress to church? Is it appropriate to allow their son to dress up in his mother's shoes and clothing—unless neighbors and relatives are visiting? Can Snow White toys be acceptable at home, but not taken to school for "show-and-tell"?

In general, children are sharply attuned to the meanings behind parental rules and are aware of subtleties of parental feelings that the parents themselves might not even be aware of. If parents permit or even encourage certain types of behavior inside the family but not outside, or instruct children not to act on their choices, the message is clear that this behavior is tolerated only if

it is a secret and that it is shameful if displayed in public. But parents' choice need not be simply whether to encourage cross-gender behavior versus to forbid it. Within their family they can discuss the importance of individual differences and model respect for personal choices. Open discussion with the child's grandparents, aunts and uncles, and siblings usually will diminish the feelings of shame and guilt that often complicate family relationships and will help to ensure a supportive environment for the child's growth. The gripping movie "La Vie en Rose" depicts some common tensions in families surrounding a child with gender-atypical preferences and behaviors.

Families have the opportunity also to help the child learn techniques of recognizing and combating the damaging effects of stigma. For example, parents can explain that this behavior is not typical of boys/girls of his/her age and that he/she may get teased or questioned about it. They can discuss with their child(ren) that unusual behavior may be unfairly criticized and provide strategies for them to resist teasing and ostracism. Learning and practicing at home an appropriate response to anticipated questions or taunts is like providing a protective shield for a child as he/she ventures out of the family and into a world of peers.

If only one could predict that a particular child were going to grow up to be a gay adult! If parents knew of that outcome, the child's early declaration in the form of cross-gender behavior would give the family a head start. And what a gift—for the *child,* so that his/her middle childhood and early adolescence would not need to be so conflicted and dissonant as they are for many young people who are on their way to becoming gay or lesbian; and for the *parents,* so they can grow into an understanding of who their child is and avoid the typical sense of loss and altered expectations that occur when a child "comes out" to them in late adolescence or adulthood.

There is no way to be certain if a particular child will become gay or lesbian. Pediatricians can, however, help parents to consider how they might feel if their child were indeed to be gay or lesbian. In this way, discussion about a child with atypical gender role behavior or a diagnosis of GID provides a helpful opportunity for parents. They and other members of their family will thereby have the opportunity to spend some time addressing the possibility that their child might be gay or lesbian well before he/she is an adolescent. Most families can come to accept a homosexual son or daughter, especially if given adequate time and support to come to such acceptance. Physicians can be influential as a source of support, information, and guidance for all members of a family. Tolerance for the possibility that the child might be transgender is often more difficult to accept. The lesser likelihood of this outcome suggests that it is probably better to wait in introducing that possibility until later if it seems more likely.

Parents of a child with atypical gender-role development must modify their language and the expectations it reflects so that the child's adult sexual orientation remains an open question. Avoid assumptions! Instead of discussions about future wives or husbands, parents could systematically use the language of "partners." The family could make a point to watch TV programs

together about gay and lesbian adults and families and to read books about gay and lesbian heroes in history and in fiction. News stories about gay and lesbian issues can be discussed with compassion and implicit acceptance; stories about discrimination and negative stereotyping can be highlighted as inappropriate. None of these actions is necessarily very different from how parents of *any* child might choose to act—but for parents of a child who is demonstrating cross-gender behavior, these issues are brought to the center of their attention. Implicit and explicit statements of acceptance are directly protective of their child's development and not simply reflections of broad sociopolitical values.

Another approach that is important for parents of a child with atypical gender preferences is to help teachers, neighbors, and other children to accept their child's play and playmate preferences and to value her/his broad contributions. Classroom discussions about the value of diversity will foster tolerance and provide a framework of acceptance for the benefit of *all* the children. Parents have the opportunity in this way to make their child's school safe and explicitly accepting of diversity. Acknowledgement of diversity in children's play and playmate preferences, and in their family constellations, is appropriate for all children in early childhood classrooms. As children get older, discussions and reading materials might include diversity of sexual orientations. Imagine how refreshing for a middle school boy who wonders if he—or a friend—might be gay, to find books in the school library about gay dads raising children together, or a biography describing the accomplishments of a gay leader.

Most difficult for parents is coming to terms with considerable ambiguity and uncertainty. If the behaviors labeled as GID are "prehomosexual" in two-thirds of these boys, what about the other third? What factors either before or after the evaluation contribute to their adult sexual orientation? Is there any way that parents can influence their child's developing sexual orientation, and if so how? How could they ensure that their attempts were not harmful to the child? An important role for child health professionals is to support children and their families as they grapple with these uncertainties, and to provide them with resources in the form of reading materials and contact information for organizations of other parents and children with similar questions. For some families, referral to a psychotherapist with expertise in issues related to sexual orientation is appropriate as an adjunct to pediatric counseling.

DETERMINANTS OF SEXUAL ORIENTATION

Complex Paradigms

Considerable scientific controversy is contaminated with heated emotion and political implication about the origins of diversity in sexual orientation. The fulcrum of the debate is whether sexual orientation is *chosen* or *inborn.* It is fueled by the erroneous belief that society should and would be more tolerant of homosexuality if it were proven to be "involuntary", and furthermore

that knowledge of its "inborn" biologic basis is necessary to prove that it is involuntary. The logic of this argument is flawed in several ways:

(1) It is simplistic to equate "involuntary" with "inborn." The vast literature on the power of cultural determinants of behavior, beliefs, and language attests to the fact that much of human behavior that is not based on biology is nevertheless not consciously chosen;
(2) Extensive experience documents the futility of individuals' attempts to change their sexual orientation (at least among men) and thus provides evidence that homosexuality is not voluntary, whatever its origins;
(3) It is a suspect ethical standard that would justify restriction of equal freedoms and protection to certain members of a society and would allow discrimination against them based on whether they had *chosen* their particular way of being or it had been imposed on them. Few would argue that religion is either inborn or involuntary, and yet diversity in religious belief and practice is valued and protected in most enlightened societies; and
(4) Modern science increasingly erodes the notion of biological determinism. We understand increasingly that biological factors and socio-cultural factors interact to create, maintain, and change the emotions, intellect, and behavior of humans. Just as biology does not determine destiny, it is dangerous to allow it to dictate social policy.

The futility of the typical polarization between "biologic" and "social" influences on sexual orientation is described by one author as follows: "It is impossible to separate biological and psychological contributions... the public debate about the ontogeny of sexual orientation seems especially misguided because there is profound agreement between scientists who favor psychosocial theories and those who favor biological theories that sexual orientation is determined very early in life and is not a matter of individual choice" (Breedlove, 1994).

In fact, we know remarkably little about the forces that shape human sexual orientation. Proponents of biological determinism argue that innate biological phenomena determine sexual orientation, while social constructionists conceptualize sexual orientation as created largely or entirely by social and cultural factors and independent of biological differences. The true origin of diverse sexual orientations is likely to involve both some biological and some contextual factors (Byne & Parsons, 1993).

Some have argued that sexual orientation should not be seen as a fixed attribute of individuals at all, but rather as fluid and changeable with growth and in response to life circumstances (Richardson, 1993). This approach is of particular importance for clinicians caring for adolescents who may be in the process of sorting out for themselves their complex and changing sexual attractions, fantasies, and behaviors. The meanings of sexual feelings, fantasies, behaviors, and sexual identity itself may change over time.

For some adolescents, the security of a "label" that defines their sexual attractions may be comforting, while for others the notion of a permanent

sexual identity that is beyond their voluntary control may raise new anxiety and constrain the breadth of opportunities they had hoped for. The task is not easy: Labeling a phenomenon too soon may prematurely close possibilities, and labeling too late may add to the weight of suffering. On the one hand, labels are useful—they give order to chaos, structure to openness, security to confusion. Knowing that one is gay is much more comforting than living with the precariousness of confused sexual identities. On the other hand, labels are destructive—they restrict where other choices are possible, they control and limit possible variety, they narrow experimentation. In the short run, labels are comforting; in the long run, they can be destructive (Richardson, 1993).

Much of the research on the origins of homosexuality has been on gay men. Some have suggested that the factors influencing sexual orientation in women may be quite different or operate with different weights. Many lesbian women do not ascribe to the "involuntary" nor to the "fixed" views of homosexuality, but rather see their sexual orientation as a personal choice that is flexible in response to new experiences and opportunities.

This research has been hampered by lack of clarity in definitions and measurement of sexual orientation, as well as the ubiquitous constraints imposed by discrimination and fear of self-identification. As a result, many conclusions have been drawn from animal studies, and most studies in humans use small and biased samples, lack control groups, and include only men. Furthermore, many anatomic studies rely on examination of the brains of men who have died from AIDS. Despite these difficulties, there is substantial evidence that biology plays an important role in the development of a homosexual orientation. The complex interplay of biologic and environmental factors remains an enigma.

Biological Factors

Inquiry into possible biologic determinants of homosexuality has proceeded throughout the 20th century. Early studies described differences in sex steroid levels, and more recent research has focused on neuroanatomy, psychoendocrinology, and genetics.

Neuroanatomic Phenomena. Several morphological differences have been found between heterosexual and homosexual men. Out of four interstitial nuclei of the anterior hypothalamus, two have been found to be larger in men than in women; one of these has been found to be much larger in heterosexual men than in homosexual men (LeVay, 1991). Increased cell number and volume have been reported in the suprachiasmatic nucleus of homosexual men (Swaab & Hofman 1990); this finding is complicated by the possibility that environmental and psychological factors play some part in the differentiation of this structure (Swaab & Hofman, 1995). An intriguing finding that the midsagittal region of the anterior commissure is larger in homosexual men than in heterosexual men (Allen & Gorski, 1992) raises questions about the possibility of differential brain lateralization as one contributor to the origin of homosexuality.

A link between cerebral lateralization, immune disease, and sexual orientation has been postulated (Geschwind & Galaburda, 1985a,b,c). This association is thought to be the result of the action of prenatal androgens on developing brain structures. Using hand preference as a marker for hemispheric lateralization, the data are inconclusive. Some studies have supported a hypothesized association between handedness and homosexuality (Becker, Bass, Dew, Kingsley, Seines, & Sheridan, 1992; Halpern & Cass, 1994; Lindesay, 1987), while others have not (Bogaert & Blanchard, 1996; Gladue & Bailey, 1995; Satz, Miller, Seines, Van Gorp, D'Elia, & Visscher, 1991). Recent studies using functional measurement of brain lateralization have found a less pronounced pattern of hemispheric asymmetry in homosexual men than in heterosexual men (Alexander & Sufka, 1993; Reite, Sheeder, Richardson, et al, 1995). Even if such differences were replicated, it still remains unclear if they contribute to differences in sexual orientation or are the result of them.

Psychoendocrine Factors. No differences have been found in the sex steroid levels of heterosexual and homosexual adults (Downey, Ehrhardt, Schiffman, Dyrenfurth, & Becker, 1987; Gartrell, 1982; Meyer-Bahlburg, 1984, 1993). Much current psychoendocrine research is focused therefore on prenatal hormones. In many mammalian species, an important role has been demonstrated for prenatal sex hormones in the development of structural differences in the brain and in sex-linked behaviors (Gerall, Moltz, & Ward, 1992; Tallal & McEwen 1991).

Most human research into the effect of prenatal sex hormones has concentrated on individuals with intersexuality and has provided contradictory and controversial results (Fausto-Sterling, 1992). Some support for the contribution of prenatal estrogen to the development of homosexuality comes from the finding of a modest association of prenatal DES-exposure with increased incidence of homosexuality in women (Meyer-Bahlburg, Ehrhardt, Rosen, Gruen, Veridiano, Vann, & Neuwalder, 1995). Women with congenital adrenal hyperplasia have been described to respond to prenatal androgens with greater propensity for "tomboyish" behaviors (Friedman & Downey, 1993). The propensity to engage in rough-and-tumble play also does seem to be influenced by prenatal androgen exposure (Erhardt & Meyer-Bahlburg, 1981).

The hypothalamic-pituitary-gonadal axis has been examined for organizing influences of prenatal hormones during critical periods of sexual differentiation (Doerner, Rohde, Stahl, Krell, & Masius, 1975). In rodents, androgen activity in the developing hypothalamus determines the signal that the adult's brain will relay to the pituitary gland in response to high levels of estrogen. If rats experience high levels of androgens at an early stage of embryonic development, the brain responds to estrogen by decreasing the pituitary's secretion of luteinizing hormone. In contrast, if the embryonic brain has not experienced high levels of androgens, the adult will respond to high estrogen by secreting *more* luteinizing hormone—the same positive feedback response that accounts for normal ovarian function in females.

Based on these animal studies, some have postulated that homosexual men may have a similar mechanism for positive estrogen feedback on the

secretion of luteinizing hormone, which is usually seen only in females (Doerner, 1988; Gladue, Green, & Hellman, 1984). This association of luteinizing hormone and homosexuality has been disputed in a large study of men and women (Gooren, 1986a,b). More recent investigations of these relationships posit complex relationships between prenatal stress, genetic factors, and psychoendocrine changes in the development of a homosexual orientation (Doerner, 1989; Doerner, Poppe, Stahl, Kolzsch, & Uebelhack, 1991).

Genetic Studies. Early suggestions of a genetic component to the determination of sexual orientation stemmed from observations of family genograms. The first reports described homosexual relatives in more than one-third of male homosexual patients and concordance for homosexuality in six of seven pairs of identical twins. A tabulation of several earlier reports concluded that some families seemed to have an aggregation of homosexual members that exceeded chance (Pillard, Poumadere, & Carretta, 1981). Several studies have reported a concordance among monozygotic male twins as between 52% and 66%, and among dizygotic male twins between 22% and 30% (Bailey & Pillard, 1991; Whitam, Diamond, & Martin, 1993). Concordance rates have been somewhat lower for women—48% for monozygotic twins and 16% for dizygotic twins (Bailey, Pillard, Neale, & Agyei, 1993). While a high degree of concordance is found repeatedly in studies of twins (Kendler, Thornton, Gilman, & Kessler, 2000; King & McDonald, 1992; Pillard, Poumadere, & Carretta, 1982), all reports also include some identical twins whose sexual orientation is unquestionably different. In addition, twins share more than genes: their family and social environments are also far more similar than those of non-twin siblings. To address this concern, a few sets of twins who have been raised separately have been studied, and they also are reported to show greater than expected concordance in sexual orientation (Eckert, Bouchard, Bohlen, & Heston, 1986; Whitam et al., 1993).

Some investigations have suggested a chromosomal marker of sexual orientation. Thirty-three of 40 pairs of gay brothers were found to have the same alleles at five adjacent marker sites at the Xq28 region of the X chromosome (Hamer, Hu, Magnuson, Hu, & Pattatucci, 1993; Turner, 1995). Unfortunately, no similar study has been done with lesbian women, nor has this initial finding been replicated.

How genes exert their influence and in combination with what other factors remains unclear. It is possible that genes influence the development of particular areas of the brain which then lead to the neuroanatomic and endocrine variations referred to above. The interaction of genetic markers with familial and social patterns may result in predictable patterns of behaviors (Bailey, Dunne, & Martin, 2000; Dawood, Pillard, Horvath, Revelle, & Bailey, 2000). What seems increasingly clear is that whatever combination of biologic and environmental factors influences sexual orientation seems to act very early in life, and to be rather tenacious. A delightful summary of the complexity involved in understanding the biologic origins of sexual orientations can be found in an essay by John Money (1993): "Sin, Sickness, or Status." The recent mapping of the human genome undoubtedly will provide more information about the genetic contribution to the determination of sexual orientation.

The complexity of these processes should not be minimized. One neuroanatomist and psychiatrist summarizes the "state of the art" like this: "While all mental phenomena must have an ultimate biological substrate, the precise contribution of biological factors to the development of sexual orientation remains to be elucidated. Does biology merely provide the slate of neural circuitry upon which sexual orientation is inscribed by experience? Do biological factors directly wire the brain so that it will support a particular orientation? Or do biological factors influence sexual orientation only indirectly, perhaps by influencing personality variables that in turn influence how one interacts with and shapes the environment as it contributes to the social relationships and experiences that shape sexual orientation as it emerges developmentally?" (Byne, 1997).

Family and Social Factors

Few differences have been found in the family and social environments of homosexual and heterosexual individuals. There is no evidence that the development of a homosexual orientation is related to traumatic experiences in childhood or adolescence such as sexual abuse (Remafedi, 1990).

Psychoanalytic, social learning, and social constructionist theories have postulated mechanisms explaining the development of sexual orientation. *Psychoanalytic* theorists believe that relationships with parents early in childhood are central to the development of gender identity, gender roles, and sexual orientation. According to traditional psychoanalytic theory, gender development is rooted in the phallic stage of psychosexual development. At about 5 years of age, the Oedipal conflict between the boy's desire for his mother and his fear of castration by his father is postulated to lead boys to shift their identification from their mother to their father and to take on his male characteristics (Friedman, 1988). The resolution of the Oedipal conflict in girls is less clear, but is thought to be driven by penis envy and involves transferring identification from the father back to the mother and thereby adopting a female role.

The acquisition of nontraditional gender roles and the development of a lesbian or gay sexual orientation are viewed traditionally as negative outcomes resulting from the unsuccessful resolution of this Oedipal conflict. Boys who fail to identify with their father and girls who fail to identify with their mother are thought to be more likely to identify as gay or lesbian as adults. This outcome is predicted for boys in the presence of a domineering mother and a weak father; a lesbian orientation is thought to result from a hostile and fearful relationship of a girl with her mother (Bieber, Dain, Dince, Drellick, Grand, Gondlack, Kremer, Rifkin, Wilber, & Bieber, 1962).

Empirical studies have not supported this theory. Studies of gay men have found no evidence that they were overindulged by or more strongly attached to their mothers than were heterosexual men (Bene, 1965a; Siegleman, 1974). Research on the early family relationships of lesbian women have suggested that their mothers tended to be dominant and their fathers weaker (Bene, 1965b; Newcombe, 1985), contrary to theoretical predictions.

Social learning theory posits that the family interpersonal environment and parental expectations are determining factors in the development of sexual orientation (Mischel, 1966). Important processes are thought to be *modeling* and *differential reinforcement.* Parents are known to treat their sons and daughters differently as early as infancy. As children get older, parents and other adults consistently encourage different activities for boys and for girls (Fagot, 1974; Rheingold & Cook, 1975; Shakin, Shakin, & Sternglanz, 1985). Peers consistently reinforce sex-typed play and activity choices and punish cross-gender preferences (Carter, 1987). These theorists suggest that children develop culturally atypical patterns of behavior and gender roles as a result of parental modeling and/or reinforcement (Bussey & Bandura, 1999).

Some social learning theorists suggest that fathers may be more important to children's gender-role development than mothers (Block, 1976). Fathers have been observed to make greater distinctions between sons and daughters and to interact with boys and girls in ways that are far more differentiated than do mothers. From this observation comes the prediction that fathers' behavior will promote typically gender-typed behavior in both boys and girls more strongly than will mothers' behavior. Fathers are said to be more likely to encourage their sons to take on an instrumental, independent style of behavior, whereas they will encourage their daughters to seek help and be more dependent (Johnson, 1963, 1975).

Social constructionist theories emphasize individuals' active role, guided by the culture, in creating their sexual identity (Kitzinger, 1987; Simon & Gagnon, 1987; Tiefer, 1987). According to these theorists, individuals first become aware of cultural norms for sexual encounters and then develop internal fantasies and interpersonal scripts associated with sexual arousal. Many children may experience attraction to peers of the same gender, but social sanctions force them to reject them (Plummer, 1975).

DEVELOPMENT OF A GAY IDENTITY DURING ADOLESCENCE

Several authors have attempted to describe the "typical" trajectory of the development of a stable homosexual identity (Savin-Williams, 1988; Troiden, 1988). Such a task is daunting because of the many factors that intersect to affect an individual's adult sexual orientation.

The expression of sexuality is a result of a unique mix of biological, psychological, social, and cultural factors (Savin-Williams, 1998). Individuals would not be expected to have identical pathways, concerns, or difficulties. Indeed, in many domains of development, gay and lesbian youths share the experiences of all other adolescents irrespective of sexual orientation; in other domains, gay youths may share elements of a common pathway with other gay youths, or may forge their own particular variant. It seems likely that a developmental trajectory is a "probabilistic pathway through time and space" that is shaped by three sets of factors: "(a) characteristics of the developing adolescent, (b) influences of the immediate environment, and (c) opportunities and

constraints inherent in the broader context" (Steinberg, 1995). Adolescent behavior is influenced not only by internal biological processes, but also by proximal forces, such as friends and family, and distal influences, such as heterosexism and homophobia.

Our understanding of this process is hampered further by several other factors. (1) Fear of reprisals and discrimination restrict recruitment for research. Participants in early studies of gay youth were hustlers, street-walkers, homeless youths, and youths involved in mental health or substance abuse treatment programs. Clearly it would be inappropriate to generalize findings from these studies to larger cohorts of young people. (2) Most studies until recently have investigated the identity development exclusively of males. (3) Mainstream societal attitudes about homosexuality have changed considerably over the past two decades. While considerable stigmatization and discrimination continue to exist, it has become easier for young people, at least in some parts of the country, to acknowledge and disclose their questions and early homosexual feelings to some significant adults and peers.

Nevertheless, some consistent patterns in the process of development of mature homosexuality have been described. Most commonly cited are the pathway outlined by Cass (1979; Table 3.2) and that proposed by Troiden (1988) which is described in detail in Chapter 4. Many gay youths report a vague but distinct sense of being different from other boys during the elementary school years. They experience a sense of "not fitting in" and are aware of not having the same interests as other boys. They describe both an awareness

TABLE 3.2. Stages in Lesbian and Gay Identity Formation (Summarized from Cass, V., 1979)

I.	**Identity Confusion** Recognition that "there is something about me/my behavior/thoughts/feelings that could be called homosexual."
II.	**Identity Comparison** Feelings of estrangement and alienation are felt as the possibility of membership in a stigmatized minority group is entertained. Feelings of rejection, grief common.
III.	**Identity Tolerance** Management of difference between self and members of the heterosexual majority; careful disclosure of identity to selected others.
IV.	**Identity Acceptance** Understanding of oneself as a member of a minority but valued group; increasing sense of peace and fulfillment with inclusion in the category of homosexuals; increasing disclosure to others.
V.	**Identity Pride** Recognition of clash between dominant heterosexual population and personal acceptance of self as non-heterosexual; devaluing of heterosexuality and strong sense of group solidarity with homosexual community.
VI.	**Identity Synthesis** Interactions with others at increasingly public level; sense of belonging to a broadly diverse world community; heightened self-esteem and empowerment.

of a normative standard of how boys are "supposed to" feel and act and a belief from an early age that they violate this ideal. The differences described include an emotional attraction to other boys and men, a desire to engage in play activities more characteristic of girls, a preference for girl playmates, and disinterest in typical boys' activities, especially team sports and play involving physical aggression.

Many gay young adults recall harassment and teasing from peers in elementary school as a consequence of associating with girls, spending considerable time alone, not participating in sports, and being quieter and more "sensitive" than their peers.

These feelings of marginalization are not recalled solely by gay youths. Heterosexual boys also may feel "left out," have attractions to males, enjoy "feminine" activities, and avoid aggressive pursuits. The dearth of data on the development of sexuality among heterosexual individuals makes interpretation of these patterns somewhat risky. Nevertheless, compelling research demonstrates that gender nonconformity during childhood is one of the best predictors available of adult homosexuality (Bailey & Zucker, 1995; Bell, Weinberg, & Hammersmith, 1981).

Many young gay men describe disinterest during adolescence in the usual "dating games" and other sexually-connoted activities. On the other hand, others recall that they were quite masculine in appearance, behavior, and interests, or indeed that they had very few sexual interests involving either male or female partners. Many gay adolescents are as active and successful in sports as many of their heterosexual peers, while some may prefer and participate in individual rather than team sports, such as swimming, track, and tennis.

Around the time of puberty or shortly thereafter, gay youths may begin to label their same-sex attractions as "homosexual" and enter the period sometimes described as "identity confusion" (Troiden, 1988). Young adolescents seldom have the experience or the language to make sense of what they are feeling. The increasing visibility and acceptability of homosexuality in our culture may provide for adolescents a framework to explain their homoerotic feelings and to clarify their meaning. Boys' increasing awareness of same-sex attractions around puberty is often unwelcome and stressful. Savin-Williams describes the process that occurs between recognizing these attractions and labeling oneself as gay in this way: "The deepness of the valley between labeling *feelings* as gay and labeling *identity* as gay may be partially perpetuated by successful attempts to suppress, deny, rationalize, intellectualize, or sublimate same-sex attractions" (Savin-Williams, 1998).

There has been less systematic investigation and analysis of the process of lesbian development. It seems that among women there are more idiosyncratic pathways and wide variability in the timing, sequence, and outcome of developmental stages (Diamond, 1998; Parks, 1999). The development of bisexuality appears to take an even more variable course (Savin-Williams, 1995; Weinberg, Williams, & Pryor, 1994).

Same-sex orientation may develop later and more abruptly among women. Furthermore, neither feelings of differentness nor childhood gender atypicality

correlate as strongly with same-sex orientations among women as they do among men. A recent study, for example, found that only 60% of lesbian women reported any childhood indicators of homosexuality, and even among those who did there was considerable variation in their experience (Diamond, 1998).

Many teenagers of both sexes have sexual encounters with both boys and girls. For teenagers who think they may be lesbian or gay, heterosexual sex allows them to (1) test out the possibility that they may be gay; (2) accede to the desires of a favored friend who wants sexual involvement; (3) expand their range of experiences, satisfying some level of curiosity; (4) satisfy their need for physical/sexual release and pleasure; (5) satisfy a need for intimacy that is not easily available to them otherwise; and (6) respond to pressure from peers to engage in heterosexual activities. For some teenagers, the lack of pleasure or excitement they get from heterosexual sex may confirm their emerging self-identification as gay or lesbian.

Women appear to experience their first same-sex attractions and begin questioning their sexual identities at later ages than men do. Associated with this later development of a stable sexual orientation, lesbian women report higher rates of heterosexual activity prior to self-identification as lesbian than do homosexual men. In addition, nearly 40% of participants in one study reported having undergone changes in their sexual attractions over time that they did not attribute to changes in awareness (Diamond, 1998). For many women, involvement in a sexual relationship may be their first clue to the possibility of their lesbian orientation (Levine, 1997).

Increasing numbers of gay and lesbian youths are defining themselves as homosexual at increasingly younger ages, largely because of the recent increases in the visibility and acceptability of homosexuality in the media and more broadly in mainstream culture, and the growth of a vocal and extensive gay youth culture. Table 3.3 illustrates the decreasing age at which several identity milestones are recalled by male adolescents and young adults.

Helpful in the process of self-identification are some consistent factors: (1) the presence of a gay or lesbian family member who has disclosed his/her sexual orientation; (2) the presence of a gay or lesbian role model, for example a teacher; (3) the support and acknowledgement of heterosexual friends; (4) the presence of gay-positive messages transmitted through the media in the youth's community; (5) the increasing visibility of gay issues, for example in the media, in bookstores and libraries, and through the development of gay youth groups and gay/straight alliances in high school or in the community; and (6) open discussions of sexuality in the course of confidential health care services.

The disclosure of their sexual orientation to another person ("coming out") for the first time is an important developmental milestone. Disclosure is often carefully timed and orchestrated; gay adults often remember the circumstances, the feelings, and the reactions of the other person for years afterwards. Common first disclosures are to a teacher or other adult role model or family member who is known to be gay, or a peer who has already "come out."

TABLE 3.3. Mean Age of Developmental Milestones

	Kooden et al. (1979) N=138	Troiden (1979) N=150	McDonald (1982) N=199	Rodriguez (1988) N=251	D'Augelli (1991) N=61	Herdt & Boxer (1993) N=147	D'Augelli & Hershberger (1993) N=142	Rosario et al. (1996) N=81	Campbell & Perrin (1997) N=86	Savin-Williams (1998) N=180
First same-sex attractions	12.8	—	13	11.1	10.8	9.6	9.8	10.9	—	8
First homosexual sex	14.9	14.9	15	—	15.6	13.1	14.9	13.3	—	14.1
Label self as gay/lesbian	21.1	21.3	19	20.6	17	16.0	14.8	14.7	15	16.9
First disclosure to other	28	—	23	23.6	19	16.8	16.7	—	17	17.9

Disclosure to a nongay parent or family member is a more difficult challenge and depends tremendously on the strength of the relationships that exist between the teenager and family members and on their known or assumed attitudes regarding homosexuality. It is important that this first disclosure be done at a time and in a manner that maximizes the possibility that the reactions of the other person will be at least accepting. Pediatricians and other health care clinicians can be extremely helpful as adolescents consider to whom, when, and how they will "come out." In general clinicians should encourage gay youths to disclose their homosexuality to their parents and siblings, but because disclosure is frequently followed by disappointment, anger, and rejection from family members, it should be planned carefully.

The goal for all youths is to achieve acceptance of their sexual orientation and a positive self-identification as a heterosexual or a homosexual adult. This process has been referred to by various researchers as "integration" (Coleman, 1989), "identity synthesis" (Cass, 1979), or "commitment" (Troiden, 1988). At this stage "individuals come to see themselves as people having many sides to their character, only one part of which is related to sexuality" (Cass, 1979). Troiden describes the hallmarks of this final developmental stage to include same-sex romantic relationships, disclosure of the gay identity to others, and satisfaction with their gay identity.

SUMMARY

Almost all experts in human sexuality view heterosexuality and homosexuality as matters of *degree* rather than entirely of *kind.* People are seen as occupying various points along a continuum in their sexual behaviors and responsiveness from exclusive heterosexuality to exclusive homosexuality. Whether sexual orientations are established before birth, grow out of gender-role preferences established early in childhood, and/or are organized based on family and social experiences, people construct their sexual orientation over time by making sense of their sexual feelings in the context of the wider culture.

Nearly all models of homosexual identity formation see development as taking place against a backdrop of stigma, which affects the processes of formation and of expression of sexual identity. It seems increasingly implausible to consider that genes, hormones, neuroanatomic differences and different social environments would either have *no* part in the process or would act *alone* to result in anything so complex as human sexual behavior and orientation. Rather, biologic, temperamental, and personality traits most likely interact with the familial and social milieu in which a child is nurtured as her/his sexuality emerges (Byne & Parsons, 1993).

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4

Adolescents

And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom.

Anais Nin

Adolescence is above all a phase of the life cycle characterized by uncertainty, confusion, and changing expectations—for adolescents and for their parents. The feelings and behaviors of middle childhood no longer are appropriate, but the adult demeanor that will replace them has not yet gelled. Parents are no longer welcome to know and monitor their children's day-to-day activities, but their presence is critically needed to help teenagers to navigate new relationships and increasingly complex academic and social expectations. The always-challenging responsibilities of parenting take on new dimensions as the old rules no longer hold, but new ones have not been defined. Family relationships strain as they strive to adjust to continual inconsistencies and rapid changes.

Developmental tasks of adolescence include the development of formal operational thinking, new reciprocal relationships with peers, planning for educational and vocational goals, and the attainment of independence. Erik Erikson describes the dilemma to be resolved during this period "identity vs. identity confusion" (Erikson, 1963). Others have referred to adolescence as a second process of individuation, analogous to that of toddlerhood (Blos, 1962). There is no doubt that it is a stage of intense turmoil during which a new equilibrium must develop in relationships with peers and family.

The development of an adult understanding of and attitude toward sexuality is in flux as well. Physiologic changes of adolescence combine with media demands and social expectations to put sexuality under an intense spotlight during this period. Sexual and aggressive drives are stronger than at any other time of life. Learning to express and control these drives in a socially-condoned fashion, i.e. to become comfortable with their sexuality, is one of the formidable tasks that adolescents have to master.

Among the troubling phenomena of adolescence is the egocentric belief that they are "on stage," that people are watching and potentially criticizing them. For teenagers who feel "different" and marginalized, the intensity of this common and normal worry is even more dramatic. Adolescence is characterized by conformity, a wish to "fit in," to be "just like the others." Teens who are not inclined to participate in normative adolescent activities, such as sports and aggressive play (for boys) or domestic/romantic pastimes (for girls), and who are not comfortable taking part in prescribed heterosexual dating activities, are readily ostracized, teased, and further marginalized. These teens may endure suggestions that they might be gay or lesbian, a prospect—which may have already occurred to some of them—that is generally greeted as a threat rather than a promise. Whether or not these teens eventually do identify themselves as heterosexual or homosexual, the stigmatization and ostracism of adolescence is painful and often profoundly damaging to their emerging identity formation and self-esteem.

The onset of sexual experimentation typically occurs during early or middle adolescence and frequently includes sexual activity with both opposite-sex and same-sex partners. The timing and process of consolidation of an individual's sexual identity depends on many factors, including access to reliable information, the availability of supportive peers and adult role models, and the breadth of individual experience and sophistication. Adolescents may recognize and identify themselves as gay or lesbian during early, middle, or late adolescence; some do not come to understand their sexual orientation until their twenties or even later (especially women). The age of self-identification as gay or lesbian appears to be decreasing (Savin-Williams, 1998). Recent anecdotal accounts report children as young as 11, 12, or 13 feeling certain of their homosexual orientation and disclosing it to their parents (Wildman, 2000). It may be especially difficult for parents to understand how their children can know they are gay or lesbian in early adolescence. The family may need to maintain supportive and constructive communication as they all develop new perspectives and systems of support.

Undoubtedly many factors coalesce to help individual adolescents come to terms with their personal sexual orientation and to solidify their sexual, emotional, and gender identity. It is critical for teenagers to find a way to confront the stigmatization of peers and to identify a supportive community of peers and of adult advisers available to them as they struggle with and come to accept their own identity in all its aspects. Teachers, sports coaches, physicians, and nurses are among the adults to whom teens can turn for help in this process and who can provide advice and support to allow them to disclose their sexual orientation to family members and friends.

EPIDEMIOLOGY

It is difficult to know with any certainty how many adolescents identify themselves as exclusively or even predominantly homosexual. Definitions

differ, as does the methodology of obtaining the information (face-to-face interviews, telephone surveys, or anonymous mail surveys). Self-selection bias is necessarily introduced into all samples as a result of the still-pervasive stigma associated with homosexuality, especially in adolescents. The real and perceived dangers involved in recognition and identification make all data no better than rough estimates (Black et al., 2000; Gonsiorek, Sell, & Weinrich, 1995; Sell, Wells, & Wypij, 1995). Furthermore, little is known about the stability of self-identification as homosexual during adolescence. Some have suggested that women are more likely than men to experience variations in their sexual attractions and orientation over time. Many adolescents have questions and concerns about their sexual orientation and sexual behavior, and many experiment with sexual activity with both men and women. In contrast, adolescents who think they may be gay or lesbian, like adolescents who are sure of a heterosexual orientation, may not have any sexual experiences at all during adolescence.

Gay and lesbian adults recall heterosexual experiences as teenagers, and heterosexual adults recall same-sex experiences. In one study, almost 12% of the respondents reported some homosexual contacts during adolescence, but only 6.7% had had any after 19 years of age (Fay, Turner, & Klassen, 1989). Another study reported similar findings: up to 25% of men reported having had at least one homosexual experience, but only 10% reported any after 15 years of age (Seidman & Rieder, 1994). These data confirm that same-sex behavior is more frequent during adolescence than during adulthood, at least among men. For both men and women, a period of true bisexuality may occur during adolescence prior to a fixed recognition of adult sexual orientation.

Kinsey's original study of sexual behavior reported that from puberty to age 20, 28% of boys and 17% of girls had had at least one homosexual experience (Kinsey, 1948, 1953). He reported that 4% of the men in his sample practiced exclusively homosexual behavior from adolescence through adulthood. In another study, 17% of 16- to 19-year-old boys and 6% of girls of the same age reported at least one homosexual experience (Sorenson, 1973), while in yet another only 1.1% of junior and senior high school students described themselves as predominantly homosexual or bisexual. In this large anonymous population survey, more than a quarter of middle school students felt uncertain about their sexual orientation, and increasing numbers of students identified themselves as either homosexual or heterosexual by the time they left high school. By 18 years of age, only 5% of students reported being "uncertain" about their sexual orientation (Remafedi, Resnick, & Blum, 1992). Recent population-based data suggest that the prevalence of exclusive homosexuality among young men is between 1% and 4.5% (Blake, Ledsky, Lehman, Goodenow, Sawyer, & Hack, 2001; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001; Russell, Franz, & Driscoll, 2001).

Homosexuality has existed in all societies and among all cultures, but negative stereotypes and socially-sanctioned discrimination have rendered it taboo and hidden. Most of the information available about the prevalence of homosexual activity and orientation stems from middle-class, well-educated,

and Caucasian populations. The stigma associated with homosexuality is even greater among people of color, certain religions, and among developing nations. Little is known about variations in the prevalence of homosexuality associated with differences in ethnic, religious, and racial affiliations, and among people of lower socioeconomic status. Considerable evidence suggests that the prevalence of homosexual orientations varies little among cultures and ethnic groups, though attitudes about it vary vastly.

DEVELOPMENT OF SEXUAL IDENTITY

The acquisition of a stable adult homosexual identity is a long and complex process (Cass, 1979; Cox, 1996; D'Augelli, 1996; Savin-Williams, 1988). Gay male adults frequently remember a vague sense of differentness during early or middle childhood, but emotional and physical attractions toward people of the same gender generally surface later in childhood or around the time of puberty. Among the best-articulated models of the trajectory of development of a gay identity during adolescence is that described by Richard Troiden (1988,1989). While he describes four discrete stages in the development of a gay identity, Troiden conceptualizes the process of homosexual identity formation as analogous to a horizontal spiral and says that "progress through the stages occurs in back-and-forth, up-and-down ways; the characteristics of stages overlap and recur in somewhat different ways for different people. In many cases, stages are encountered in consecutive order, but in some instances they are merged, glossed over, bypassed, or realized simultaneously" (Troiden, 1993).

Religious, racial, and ethnic affiliation results in differences in the timing and the process of sexual identity development, disclosure to family members, and sexual behavior (Dube, 1999). Meanings, values, and attitudes about sexuality and gender differ across different ethnic and cultural communities (Greene, 1994a,b; Chan, 1989; Icard, 1986). Homosexuality represents in some cultures a betrayal of family norms, a rejection of ethnic heritage, or a sin. Relatively low rates of disclosure to families have been reported therefore among Asian, African-American, and Latino gay men and lesbians (Garnets & Kimmel, 1993; Tremble et al., 1989). Lesbian and gay youth from ethnic/racial subcultures have to manage more than one stigmatized identity, often without family support, creating additional stress and isolation.

Description of Stages

Nevertheless, Troiden outlines a typical process in the development of a stable homosexual identity among males. The process may differ for females. He delineates four stages in this process: sensitization, identity confusion, identity assumption, and commitment (Table 4.1).

Stage *1: Sensitization,* The sensitization stage occurs before puberty and is not defined as being in the realm of sexuality. Sensitization is characterized by generalized feelings of marginality and children's perception that they do not

TABLE 4.1. Stages in the Formation of a Homosexual Identity*

Sensitization
Gender-neutral or cross-gender interests; feelings of marginality and difference from same-sex peers.

Identity Confusion
Same-sex arousal and/or sexual activity; absence of heterosexual arousal; inner turmoil and confusion.
Problematic responses: Deny or seek change of homosexual feelings; inhibit homosexually-oriented interests, activities; avoid situations that precipitate or confirm homosexual desires; become socially isolated to avoid being "discovered"; redefine homosexual attractions as temporary, situational, or a "special case"; become immersed in heterosexuality, often including antihomosexual attitudes and actions.

Identity Assumption
Self-definition as homosexual; acceptance of same-sex contacts and activities; exploration of homosexual subculture and sexual activity.
Problematic responses: Same-sex activity kept secret, avoided, or criticized; stereotyped "homosexual" behavior paraded.

Commitment
Homosexual identity accepted and disclosed to heterosexual family and peers; same-sex intimacy; involvement with homosexual community.
Problematic responses: Homosexual identity kept secret and resulting social isolation; escape through alcohol and other drug use; depression and diminished self-esteem through internalized homophobia.

* Adapted from Troiden, 1988, and reproduced by permission of *Pediatrics in Review*.

share common interests and activities with same-sex peers. Homosexual men and women report almost two times more often than heterosexual controls having felt "very much" or "somewhat" different from other children during grade school (Bell, Weinberg, & Hammersmith, 1981). This sense of differentness arises largely from their gender-neutral or gender-atypical interests and behaviors, not because of same-sex attractions or sexual activities. Lesbian women remembered feeling different because they were more "masculine" than other girls, more interested in sports, and did not enjoy typical girls' activities, such as hopscotch and playing house. Similarly, homosexual males reported that they felt odd because they did not like sports, or were "feminine," enjoyed solitary activities, such as reading, drawing, music, and did not tend to enjoy typical boys' sports, such as football and baseball (Bailey & Zucker, 1995).

Some gay and lesbian adults report particular childhood attractions to same-sex adults—often an uncle or aunt or an athletic coach. For example, a gay youth reminisces: "My first hint that I was gay came when I was 11 years old in Boy Scouts. We would go on camp-outs, and there were these other boys that I felt attracted to. There was nothing physical about it or sexual about it. When I look back on it now, I had crushes on them. Then later it started to develop into something physical and sexual. In eighth grade I started thinking, 'Well, gee, maybe I'm gay.' "

Stage *2: Identity Confusion.* During early adolescence lesbians and gay men come to understand that their feelings, behaviors, or both might be identified as homosexual. This realization that they might be homosexual is often surprising and is dissonant with previously held self-images, thus resulting in the "identity confusion." In the context of a heterosexist social environment, considerable distress and uncertainty often surround this newly-ambiguous recognition. These adolescents are no longer comfortable with their previously-assumed heterosexual identities, but they have not yet developed a self-perception of themselves as homosexual. The social stigma and perceived need for utmost secrecy discourages adolescents from discussing their emerging desires and activities with family members or friends, resulting in increasing social isolation.

The age at which this early stage of recognition occurs has decreased over the past two decades. Formerly gay men were said to begin to suspect that they might be homosexual at an average age of 17 and lesbians at an average of 18 years (Schafer, 1976). Data collected more recently suggest much earlier onset of this questioning (see Table 3.3). In a Massachusetts study, for example, college-age men and women who identified themselves as gay or lesbian were asked when they remembered being sure of their sexual orientation. Before 12 years of age, 13% of men and 7% of women believed themselves to be homosexual, and by the age of 19, 71% of the women were sure they were lesbian, and 48% of the men identified themselves as gay (Campbell & Perrin, 1997).

Lesbians and gay males typically respond to identity confusion in one of several ways: denial, repair, avoidance, redefinition, and/or acceptance. Which of these strategies they choose may determine in part the level and types of risk they will encounter in the process of their development through adolescence. ***Denial*** reflects simply ignoring the homosexual feelings, fantasies, or activities. Many young adolescents continue to act as if they are heterosexual, struggling with ambivalence and feelings of inauthenticity as they participate in typical adolescent social and romantic activities. For some this may include promiscuous heterosexual activity and include the risk of pregnancy. Others actively limit their interactions with same- and opposite-sex peers in order to avoid the challenges inherent in them, in so doing increasing their isolation. ***Repair*** involves attempts to eradicate their homosexual feelings and behaviors, often soliciting the help of religious or conservative "therapies." There is no evidence that these attempts to "cure" homosexuality do anything but increase confusion and guilt (Stein, 1996). Some reports suggest that they can lead to lasting damage to adolescents' self-esteem and mental health (Haldeman, 1991). Attempts at ***avoidance*** result from the belief that their homosexual fantasies and behaviors are unacceptable. Some adolescents actively avoid learning about homosexuality, fearing that the information they obtain might confirm their suspected homosexuality. Others attack and ridicule homosexuals and homosexuality as a way to fend off their worry about their own sexual orientation. Still others avoid their conflicts by abusing various chemical substances, thus temporarily relieving their identity confusion. ***Redefining*** their homosexual feelings and behaviors refers to seeing them as a "special case,"

evidence of bisexuality, or as a temporary phenomenon. Homosexual feelings may be seen as one-time occurrences, or as a stage or phase of development that will pass in time rather than reflective of a new emerging identity.

The stigma surrounding homosexuality contributes to this identity confusion by discouraging adolescents from discussing their emerging sexual desires and activities with either peers or their families. The notion that they might be homosexual often creates considerable consternation, guilt, and secrecy. Lack of available information and accurate knowledge about homosexuality and a paucity of recognizable role models also contribute to identity confusion. This stage at which gay and lesbian adolescents, and those who are questioning their sexual orientation, are particularly vulnerable is also one when they are often particularly open to approaches by supportive adults (e.g., teachers, school nurses, physicians) who can support and advise them.

Increasingly adolescents are coming to a successful resolution of identity confusion and finding ***acceptance.*** With acceptance, men and women acknowledge that their behavior, feelings, and fantasies may be homosexual and seek out additional sources of information to learn more about their sexual feelings. Their gradual recognition that they are homosexual and that there is a community of people with somewhat similar histories and feelings may diminish their sense of isolation and provide them with a reassuring label for the differentness that many of them have felt for several years. Adolescents who accept the possibility of homosexuality are poised to enter successfully the third stage of identity development.

Stage *3: Identity Assumption.* This stage of adolescence begins with self-definition as homosexual, tolerance and acceptance of this new identity, regular association with other homosexuals, and (usually) sexual experimentation. When teenagers accept their homosexual identity and present themselves in this way to other homosexual peers, the lengthy and complex process of identity disclosure begins. Adolescents develop the ability to align themselves through affiliations with others in the homosexual community. As they perceive that they belong to a world that includes others with similar histories and concerns, the pain caused by stigma and discrimination lessens. It is helpful for adolescents during this stage to find and nurture personally meaningful contacts with experienced homosexuals, so that they can obtain accurate information, see that homosexuality is socially organized, and that a group exists to which they may belong. Positive experiences with other homosexual peers facilitate comfort with the homosexual self-definition. This process diminishes feelings of solitude and alienation and gives adolescents role models from whom they can learn strategies for stigma management, the range of opportunities available to them, and the norms governing homosexual conduct.

Adolescents who do not successfully navigate this stage may maintain an internalized stigmatizing view of homosexuality, experience self-hatred and despair, and avoid homosexual activity. Others may express their homosexuality in an exaggerated and highly stereotyped fashion. Most common is the attempt to pass as heterosexual, concealing their sexual preferences and behavior from heterosexual family, friends, and colleagues in order to avoid

stigmatization. This mechanism, known as "passing," results in leading "double lives," segregating their social worlds into peers who are heterosexual and peers who are homosexual. "Passing" results in continuing fear and the constantly draining efforts of maintaining secrecy: "careful, even torturous, control of information" (Humphries, 1979).

Stage 4: Commitment. The final stage, commitment, occurs when the individual's homosexual identity is internalized and integrated. Self-acceptance and comfort with the identification as homosexual are its hallmarks, and homosexuality is accepted as a way of life. Individuals generally report greater happiness after their self-identification. External indications of commitment include the development of same-sex intimate relationships, a widening circle of homosexual contacts, and increasing desire to disclose their homosexual identity to heterosexual friends and family. When Bell and Weinberg (1978) asked homosexual adults whether they would remain homosexual even if a magic pill would enable them to become heterosexual, 95% of the lesbians and 86% of the gay males claimed that they would not take the magic pill.

During all phases of this developmental progression, support of family and friends facilitate homosexual identity formation. Individuals feel more capable of acting on their sexual feelings and recognizing their meaning when they believe that those close to them will accept them for themselves. Fears of rejection powerfully inhibit homosexual identity formation. In addition, social stigmatization in educational and employment settings also inhibit healthy homosexual identity formation. Fears of job or income loss, or concerns about endangering professional credibility may force homosexual adolescents and young adults to adopt destructive patterns of coping.

More recent theorists suggest that this sequence of stages is too linear and fails to account for other aspects of identity formation based on race, gender, and ethnic background. Moreover they contend that widespread disclosure need not be the only measure of a mature and integrated identity (Ryan & Futterman 1997). Many factors such as legal and economic constraints, racial and ethnic group membership, geographic area, family situation, and the availability of support systems determine the extent to which disclosure is possible.

Variations Among Women

There has been less systematic investigation and analysis of the process of lesbian development. Early theoretical models described a linear and orderly progression from feelings of marginality to feelings of self-acceptance and pride in a new minority identity that did not vary significantly between men and women (Cass, 1979, 1984; Troiden, 1988). More recently it has become clear that there are more idiosyncratic pathways and wide variability in the timing, sequence, and outcome of developmental stages especially among women (Diamond, 1998; Parks, 1999). A historical analysis suggests that the typical age at which women became aware of their homosexuality, disclosed it, and initiated sexual involvement has decreased incrementally over the past

30 years (Parks, 1999), and emphasizes wide geographic, socioeconomic, and individual variability.

Some have challenged the assumption that sexual orientation always is a stable trait that affects the process of individual development from an early age and is fully formed by adolescence (Troiden, 1988). Some women appear to recognize their homosexual attractions and identity much later than others, as late as their thirties (Diamond, 1998). Inconsistencies among women's prior and current behavior, ideation, and attractions have been documented extensively (Golden, 1996; Kitzinger & Wilkinson, 1995; Rust, 1992). The development of bisexuality appears to take an even more variable course (Savin-Williams, 1995; Weinberg, Williams, & Pryor, 1994).

Furthermore, neither feelings of differentness nor childhood gender atypicality correlate as strongly with same-sex orientations among women as they do among men. A recent study for example found that only 60% of lesbian women reported any childhood indicators of homosexuality, and even among those who did there was considerable variation in their experience. Women appear to experience their first same-sex attractions and begin questioning their sexual identities at later ages than men do. Whereas a substantial proportion of young gay men report experiencing same-sex attractions, engaging in same-sex activity, and identify themselves as gay before graduating from high school, many women do not even consider the possibility of a same-sex relationship until entering college or later (Diamond, 1998). Indeed, there is some indication that many women first experience a same-sex relationship prior to any questioning of their sexual orientation, and that the progression from entering a same-sex relationship, self-identifying as lesbian, and "coming out" may take place in a far shorter time period than has been described for gay men's developmental pathway (Levine, 1997).

Associated with this later development of a stable sexual orientation, lesbian women report higher rates of prior heterosexual activity than do homosexual men. Nearly 40% of participants in one study reported having undergone changes in their sexual attractions over time that they did not attribute to changes in awareness (Diamond, 1998). It is important to recognize that individuals experience this process of sexual identity development in idiosyncratic ways (Cass, 1984), and that cultural and religious affiliations affect individual challenges in many ways (Espin 1993).

Disclosure

The process of "coming out" is rarely smooth. Teenagers typically begin to disclose their questions about their sexual orientation to close friends—preferably first to a gay or lesbian friend if they know of any who have already "come out." Adult role models (e.g., a nurse, a teacher) who are known to be homosexual may be among the first adults to whom a teenager feels sufficiently safe to disclose her/his concerns. Siblings and parents are rarely the first to hear about a teenager's emerging homosexual orientation, because the fear of rejection and approbation is great and the stakes are high. It is helpful if

adolescents are already involved in a supportive community at school to buffer difficult experiences of disclosure and "information management" of their sexual orientation.

Unfortunately many teenagers do experience rejection and loss of heterosexual friendships after they disclose their homosexual identity; they may also experience stigmatization and both verbal and physical violence. Professional mentors (teachers, nurses, physicians) who have made an effort to be available and accepting can help in making the coming-out process as affirming as possible. The ongoing dilemma of "information management" faces these teenagers repeatedly, if heterosexuality is assumed.

All too often disclosure of homosexuality occurs in a manner that is hurtful to everyone involved and inconducive to the nurturance and support that the teen most needs at this time of intense stress. If the teenager has been worried about her/his emerging sexual identity but keeping these concerns secret from family members and friends, the information may be disclosed prematurely, unwittingly, or in the course of an argument. An important role for professionals is to help these teenagers plan how they will tell their parents, siblings, and friends about their sexual identity in a manner that maximizes success for all concerned (Ryan & Futterman, 1997).

COMMUNITY-BUILDING EFFORTS

A serendipitous by-product of the epidemic of HIV and AIDS over the past two decades has been greater recognition of the diversity of sexual orientation and sexual behavior, and expansion of social discourse about sexuality in general and homosexuality in particular. Over the past decade we have seen sex education in the public media and in schools at all levels, and even gay issues discussed frequently in mainstream newspapers and TV programs. Many magazines and books are available to inform teenagers and adults about the range of responsible sexuality and its risks, and youth groups in many schools and communities create a network of peer support and role models for all students. In contrast to the earlier secrecy and the dearth of information available about homosexuality, many websites, listserves, hotlines, national organizations with local branches, and independent community youth groups are available for gay and lesbian teenagers and their friends. A growing volume of excellent fiction has been published in the past decade that helps all teenagers understand and appreciate the struggles of those teenagers who may not be heterosexual (Day, 2000).

Stigma is painful. It marginalizes and dehumanizes people. It leads people to feel vulnerable and devalued. But when people gather together and recognize their power to confront stigma, they may be motivated to mobilize resources they did not formerly recognize they had. Some gay and lesbian youth, along with their adult counterparts, have recently empowered themselves and begun to confront the isolation and discrimination that has marginalized them.

In Massachusetts, a Republican governor created in 1992 a Governor's Commission on Gay and Lesbian Youth. This group advocated for passage of the "Safe Schools Act" which was adopted in 1993. This act explicitly bans discrimination against gay and lesbian students and has spawned the development of an information and support network that continues to grow throughout the state. The "Safe Schools Program" initially was intended to counteract the alarming evidence that gay and lesbian adolescents were contemplating and attempting suicide at an alarming rate. Since then the program has broadened to include a much broader agenda. It includes expansion of social development and education not only for students who are gay or lesbian, but also for their heterosexual peers and for students who are simply exploring their sexuality. Most groups are coached by a faculty member and focus on discussions and activities intended to help teens come to understand the place of sexuality in their personal development and identity. Currently there are close to 200 schools participating in this program. The state Department of Education provides funding that supports these "Gay-Straight Alliances" in high schools across the state. In addition, the Commission has published a compendium of groups and individuals available to adolescents and young adults who are gay or lesbian or wonder about their sexual orientation. This booklet contains listings of youth groups in public and private schools, colleges, and communities throughout the state, as well as health care and social service agencies, and is distributed free of charge.

The *Gay, Lesbian, and Straight Education Network* (GLSEN) helps students start such groups in other states as well. While Massachusetts is so far the only state that supports such groups with state funding, there are now over 800 groups in high schools in 47 states. The *Indiana Youth Access Project* incorporates health, mental health, and social services provided by trained professionals as well as peer counselors and extensive outreach (Wright et al., 1998). The *Hetrick Martin Institute* provides educational, social, and medical services to gay and lesbian youth in New York City. *Project Zero* is a high school-based project initiated in Los Angeles and currently in place in Cambridge, Massachusetts, and other large cities. *Children of Horizons* is a community of gay and lesbian youth in Chicago (Boxer & Herdt, 1996). Minneapolis has *District 202;* Hartford has *True Colors.* Similar initiatives are emerging in many cities across the United States (Chandler, 1995).

These local community youth support networks generate resilience and strength among adolescents and their adult mentors, work to counteract discrimination against gay and lesbian youth, and provide a safe community to nurture their development. They provide a resource for recreation and socialization. Opportunities for public speaking and political advocacy have empowered gay and lesbian youth to reject homonegative attitudes and heterosexism and to take pride in their own personal and group identity. The Internet and national telephone "hotlines" similarly counteract the isolation created by stigma and discrimination.

Criticism of community and school-based support groups for gay and lesbian students comes from various sources. They have become a rallying point

for individuals and groups opposed to homosexuality on religious or ethical grounds. They have also highlighted questions about whether, and how explicitly, sex education belongs in schools. In addition, there has been uneasiness about whether such groups encourage teenagers to experiment sexually beyond their emotional maturity. Many concerns have been raised about whether the increased visibility and social acceptability of homosexuality might encourage high school students to identify themselves as gay or lesbian when they have not yet fully sorted out their sexuality. It is certainly true that adolescents tend to feel alienated and isolated, and as a result they are very prone to pick up on whatever beliefs and activities are espoused by a supportive group. The most important determinant of the emotional and educational value of such groups is the adult leadership. If the leader is a trusted and admired faculty member or a responsible community leader, he or she will foster discussions that encourage explorations of social and emotional development and encourage individuality in the process of sorting out the place and orientation of sexuality in each student's emerging identity.

MEDICAL AND PSYCHOSOCIAL RISKS

Despite the thawing of public attitudes towards homosexuality, gay and lesbian teenagers continue to be stigmatized, isolated, and harassed. As a result they are vulnerable to both psychosocial and medical threats to their wellbeing. In addition to societal homophobia, many homosexual youth incorporate these negative attitudes about homosexuality into a negative self-image. This internalized homophobia is manifested by self-doubts and sometimes overtly self-destructive and self-abusive behavior. Internalized homophobia may result in tolerance of discriminatory and abusive treatment by others, and abandonment or reduction of educational and vocational goals. Health professionals involved with gay and lesbian youth can play an important role in recognizing and intervening to limit self-defeating behavior before it becomes self-destructive.

Gay and lesbian teenagers are exposed repeatedly to reminders of homophobia and heterosexism. During adolescence, when the approbation of peers is critical, the rejection and both verbal and physical abuse that they face can be particularly devastating. Up to 80% of homosexual youth have reported verbal abuse; 43% have reported physical assaults, and 10% assault with a weapon (D'Augelli, 1993). More than half of gay and lesbian college students have expressed worries about their future safety. Risks to the health and wellbeing of gay and lesbian youth are described in Table 4.2 and elaborated with data from a recent population-based sample of high school students in Table 4.3.

School Problems

Academic underachievement, truancy, and premature dropout are common among homosexual youth. Schools can be especially humiliating and dangerous environments for students who are perceived to be atypical. Many

TABLE 4.2. Potential Risks to Homosexual Adolescents

Traumatic conditions:
- Anal fissures
- Rectosigmoid tears
- Hemorrhoids
- Penile edema

Urethritis:
- Gonorrhea
- *Chlamydia*

Anogenital conditions:
- *Pediculosis pubis*
- Scabies
- Tinea cruris
- Condylomata acuminata
- Syphilis
- Herpes simplex

Psychosocial difficulties:
- Family conflict
- Social isolation
- School failure
- Truancy
- Prostitution
- Homelessness
- Substance abuse
- Violence
- Depression, anxiety
- Suicide

Acquired Immunodeficiency Syndrome (AIDS) and its complications:
- Viral, bacterial, fungal, and parasitic infections
- Neoplasms
- Autoimmune reactions

Unanticipated pregnancy

Oropharyngeal conditions:
- Gonorrhea
- Syphilitic chancres
- Herpes simplex
- Condylomata acuminata
- *Chlamydia*
- Candidiasis

Gastrointestinal conditions:
- Proctitis:
  - Gonorrhea
  - *Chlamydia*
  - Herpes simplex
  - Syphilis
  - Human papillomavirus
- Colitis:
  - *Shigella*
  - *Salmonella*
  - *Campylobacter*
  - *Yersinia*
  - *Entamoeba histolytica*
- Enteritis:
  - *Giardia lambia*
  - Opportunistic gastrointestinal infections associated with human immunodeficiency virus infection
- Hepatitis:
  - Types A, B, and C
  - Cytomegalovirus

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students report verbal and physical abuse, as well as overt assault. Fear of discovery of their sexual orientation and the difficulties of maintaining secrecy in an unsympathetic environment too often prove too much to bear. When the worst insult that boys and young men call each other is "fag," and the worst insult for women is "lesbi," emotional distress and multi-problem behaviors should come as no surprise. More than three-quarters of gay and lesbian adolescents reported experiencing at least one gay-related stressful event during the past three months; 50% of them reported being ridiculed because they were gay (Rosario, Rotheram-Borus, 1996). Coming out to others, having their sexual orientation discovered by others, and being ridiculed because of their homosexuality were the most stressful events reported. In addition to these

TABLE 4.3. Distribution of Risk Behaviors, Personal Safety, and HIV Instruction among Heterosexual and Gay, Lesbian, and Bisexual Adolescents: Massachusetts, 1995

	Overall (n=3647) %	Heterosexual students (n=3496) %	Gay, lesbian, and bisexual students (n=151) %	P
Substance use, %				
Drinking (past 30 d)	54.2	53.6	69.7	.012
Marijuana (past 30 d)	33.2	32.0	57.9	<.001
Cocaine (past 30 d)	3.4	2.8	19.0	<.001
Miscellaneous drugs (lifetime)	29.2	27.3	60.5	<.001
Intravenous drugs (lifetime)	3.1	2.2	24.0	<.001
Lifetime sexual practices				
Had sexual intercourse, %	47.6	47.8	86.2	<.001
Age at first intercourse, mean (SE), Y[a]	14.3 (0.04)	14.3 (0.04)	13.7 (0.15)	<.001
Number of sexual partners, mean (SE)[a]	2.8 (0.05)	2.7 (0.05)	3.6 (0.19)	<.001
Used alcohol or drugs before last sex, %[a]	29.7	28.2	43.6	.004
Used condom during last sex,%[a]	58.2	58.4	50.7	.128
Recent sexual practices (past 3 months)				
Had recent sexual intercourse, %	33.7	33.8	68.5	<.001
Number of sexual partners, mean (SE)[b]	1.1 (0.03)	1.1 (0.03)	2.1 (0.13)	<.001
Ever been or gotten someone pregnant, %[a]	11.9	11.0	30.0	<.001
Personal safety (past 12 months), %				
Seriously considered suicide	26.3	25.4	47.3	<.001
Planned how to attempt suicide	19.1	18.2	41.8	<.001
Attempted suicide	10.2	9.4	36.1	<.001
Missed school because of unsafe environment	5.3	5.0	20.3	<.001
Threatened or injured	7.7	6.9	28.3	<.001
Property damaged or stolen	29.7	28.3	51.6	<.001
HIV-related instruction, %				
Received instruction on preventing HIV/AIDS	89.7	90.4	71.4	<.001
Received presentation from person with AIDS	59.9	51.0	46.4	.274
Taught how to use a condom	50.2	50.9	45.1	.045
Talked to parents about AIDS	58.2	58.4	55.9	.741

Note: Covariates were percentage low-income families (federal definition), kind of community, and age, sex, and race of student.

[a] Only sexually active students.

[b] Only students sexually active in past 3 months.

Reprinted from the *American Journal of Public Health* Volume 91(6), June, 2001, p. 943.

stressors, gay adolescents reported up to five times more stress unrelated to homosexuality than did heterosexual peers, such as arguments with parents and problems at school (Rotheram-Borus, 1994).

Schools are traditionally not welcoming to gay and lesbian students. In one study two-thirds of school counselors and eight of ten prospective teachers had negative attitudes about gay and lesbian youth, while 14% to 42% ignored students' jokes about their gay peers (Sears, 1991). In surveys of adolescents' experiences in high school, fewer than one in five lesbian and gay adolescents could identify *anyone* who had been supportive in school (Telljohan, 1993). One 19-year-old is quoted as saying, "If someone would have been 'out' at my school, if the teachers wouldn't have been afraid to stop the 'fag' and 'dyke' jokes, if my human sexuality class had even mentioned homosexuality (especially in a positive light), if the school counselors would have been open to discussion of gay and lesbian issues, perhaps I wouldn't have grown up hating what I was, and perhaps I wouldn't have attempted suicide" (Ryan & Futterman, 1997).

Homelessness

Homosexual adolescents are at risk of rejection by their families when they disclose their sexual orientation, especially if this disclosure is done without support and advice, too often in anger (Remafedi, 1987). Some have reported that up to half of gay adolescents have run away from home at least once as a result of family conflicts related to their sexual orientation (Remafedi, 1987). While it is impossible to know precisely, social service agencies have estimated that 25% to 35% of homeless youth in large urban centers are gay or lesbian (Kruks, 1991). Clearly, homeless youth have multiple health and social needs and are exposed to drugs, sexual abuse, and illegal activities, such as prostitution, drug-dealing, and theft. Homeless youth are at high risk for HIV infection, and prostitution and "survival sex" result in high rates of sexually-transmitted diseases. Alcohol and drug abuse are pervasive and further increase the risk for trauma and sexually-transmitted diseases (Ryan and Futterman, 1997). Homeless youth are among the highest risk groups for suicide as well (Savin-Williams, 1994).

Violence

More than half adult gay men and lesbians report that they have experienced some kind of violence on account of their sexual orientation (Herek & Berrill, 1992). Youths who report same-sex attractions and/or sexual activity are at particularly high risk to experience various forms of violence (Hunter, 1992). Data presented in Table 4.4 from the National Longitudinal Study of Adolescent Health document increased odds of perpetrating, witnessing, and being the victim of violence among youths who report attraction to people of the same sex (Russell et al., 2001). In another study conducted in nine cities

TABLE 4.4. Odds of Fighting, Victimization, and Witnessing Violence by Romantic Attraction: National Longitudinal Study of Adolescent Health

Experience of Violence	n	OR[a]	95%	CI
Physical fight (total n = 10582)				
Romantic attraction to same sex	108	0.88	0.52	1.48
Romantic attraction to both sexes	524	1.11	0.90	1.38
Medical treatment needed (total n = 10582)				
Romantic attraction to same sex	108	1.93	1.13	3.29
Romantic attraction to both sexes	524	1.57	1.16	2.12
Threat of violence (total n = 10584)				
Romantic attraction to same sex	108	1.17	0.63	2.18
Romantic attraction to both sexes	523	1.08	0.77	1.51
Jumped (total n = 10582)				
Romantic attraction to same sex	108	1.14	0.60	2.18
Romantic attraction to both sexes	524	1.37	1.01	1.84
Violent attack (total n = 10587)				
Romantic attraction to same sex	108	1.86	0.86	4.01
Romantic attraction to both sexes	524	1.43	1.01	2.01
Witnessing violence (total n = 10579)				
Romantic attraction to same sex	108	1.89	1.09	3.28
Romantic attraction to both sexes	523	1.48	1.06	2.06

Note: OR = odds ratio; CI = confidence interval

[a] Adjusted for race/ethnicity, parental education, poverty status, intact family status, age, urban/rural context, and neighborhood drug problems.

and three states, 1/3 to 1/2 of lesbian and gay junior and senior high school students reported victimization (Pilkington, 1995).

Anti-gay verbal and physical abuse has been common on college campuses as well (D'Augelli, 1989; Herek, 1993). In one report 55-72% of lesbian and gay college students reported being the victim of violence; 64% of the perpetrators were peers and 23% were faculty or staff (Savin-Williams, 1994).

Because many lesbian and gay youth are socially isolated and may feel unsure of their support even within their families, the effects of victimization are especially hard to bear. Symptoms may include depression, anxiety, and a wide range of somatic complaints (Garnets, Herek & Levy, 1992).

The threat of violence increases anxiety among youth who are questioning their sexual orientation and among those lesbian and gay youth who have not yet disclosed their homosexuality. This threat reinforces their sense of vulnerability and isolation, discourages them from "coming out," and may restrict their educational and career aspirations (Woods, 1993). Anxiety, depression, sleep disorders, substance abuse, and frank post-traumatic stress disorder may follow the experience or witnessing of anti-gay violence. Lesbian and gay youth may blame themselves for the violence, further exacerbating the

destructive effects of internalized homophobia (Hamilton, 1989; Hershberger & D'Augelli, 1995).

Responses to victimization may be moderated depending on the individual's level of self-acceptance. Teens who are involved with an organized youth support group or other supportive network, and who have "come out" and feel accepted by their families, are better able to resist the challenges of anti-gay hostility and violence (Garnets & Kimmel, 1993).

Substance Abuse

Substance use is prevalent among all adolescents in the U.S., making it somewhat difficult to discern particular risks for gay and lesbian youth. Depending on the source of data, up to 80% of high school seniors report having used alcohol, while 35 to 45% have used marijuana (Centers for Disease Control, 1995; Farrow, 1990; Ryan & Futterman, 1997).

Historically, one of the few social meeting places for gay men and lesbians has been in bars, fostering substance use and abuse. Fortunately, other venues for socialization have developed and contribute to the development of supportive community networks. Nevertheless, 25% of gay male adolescents have reported alcohol use, 8.5% frequent marijuana use, and 2.5% frequent cocaine and crack use (Skinner, 1994). In another study, overall drug and alcohol use was double in the gay and bisexual group (Bickelhaupt, 1995; McKirnan, 1989). Similar findings concern cigarette smoking among gay and bisexual men (Stall et al., 1999). A national survey of lesbian women showed rates of drug and alcohol use that were higher among young lesbians than among heterosexual women. One out of three smoked cigarettes daily; 13% were concerned about their overuse of alcohol, 5.9% were concerned about marijuana use, and 2.4% about cocaine use (Bradford, Ryan, & Rothblum, 1994).

The vulnerability of gay and lesbian youth to substance abuse is a part of the complex process of coping with stigmatization, shame, and discrimination. This risk is compounded by the dearth of emotional and practical support and information available to gay and lesbian youth. Abuse of substances is a part of the process of managing stigma. It represents one way of escaping from same-sex attractions and the conflict they engender and joining with a social group that otherwise ignores, rejects, and abuses them.

Eating Disorders

Suggestive evidence points to an increased risk for restrictive eating disorders among gay men and adolescents (French, et al., 1996; Heffernan, 1994; Herzog, 1984). Gay men have reported greater body dissatisfaction than have heterosexual men, while lesbian adolescents reported better body image than did heterosexual girls (Brand, 1992). One study found that clinical eating disorders could be diagnosed in 17% of gay men, 14% of heterosexual women, 4.2 % of lesbians, and 3.4% of heterosexual men (Heffernan, 1996; Siever,

1994). There are no systematic data regarding the prevalence of obesity among gay men and lesbians.

Depression and Anxiety

Evidence from numerous surveys documents a high prevalence of anxiety and mood disorders among homosexual adults (Cochran & Mays, 2000a,b; Standfort, Graaf, Bijl, & Schnabel, 2001). The prevalence of psychological distress may be even higher among minority ethnic and racial groups (Diaz, Ayala, Bein, Henne, & Marin, 2001).

Lesbian and gay youth also often experience depression and anxiety as they come to recognize their homosexuality and its implications (Fergusson, Horwood, & Beautrais, 1999; Lock & Steiner, 1999). Considerations of how and when to "come out" to family members and friends create heightened anxiety. With appropriate guidance and support, many teens eventually note improved self-esteem and mood after they have accepted and disclosed their identity (Herdt & Boxer, 1996). Assessment of adolescents' emotional states, degree of isolation or support, and risk for suicide are important functions for all health care professionals who help to care for teenagers.

Suicide

The increased rates of suicide among homosexual youth have been reported repeatedly. As in other areas of research with homosexual youth, studies have been hampered by nonprobability sampling and difficulties in identification of sexual orientation. Despite daunting difficulties in documenting the association between struggles with issues of sexual orientation and suicidality in adolescence, the evidence is converging that at least 50% of gay youth have seriously contemplated suicide and that at least 25% have attempted suicide one or more times before the age of 21 (Remafedi, 1994a; Remafedi, French, Story, et al., 1998).

A recent survey of adolescent health reported that 30% of high school boys who identified themselves as homosexual or bisexual had made at least one suicide attempt by the time they were 15. Lesbian and bisexual girls did not differ significantly from the generally high rates of suicidality among young women in general (Remafedi, 1998). Another report described that 39% of gay male adolescents had attempted suicide (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1994). A recent population-based survey demonstrated that high school youth who had had same-sex experiences (including but not limited to lesbian, gay, and bisexual youth) were four times more likely than their heterosexual peers to have attempted suicide during the past year (Garofalo et al., 1998). A study of twin brothers, one of whom was gay and the other not, revealed a substantially increased risk of suicidality in homosexual men that was not associated with substance use or other psychiatric conditions (Herell et al., 1999). Thus, convincing data have accumulated to determine that an increased risk of suicidality does indeed accompany homosexuality in

adolescence and young adulthood (Cochran, 2000a; Remafedi, Farrow & Deisher, 1991; Remafedi, 1994a; Rich, Fowler, and Young, 1986; van Heeringen, 2000).

Sexually-Transmitted Diseases

The medical needs of gay and lesbian teenagers are for the most part similar to those of heterosexual teenagers. All adolescents are at risk for sexually-transmitted diseases, and this risk is increased with high-risk sexual behavior. Because sexual experimentation is common in adolescence, an individual's sexual behavior often does not reflect sexual orientation. Homosexual adolescents may engage in heterosexual sex or may not be sexually active at all. Similarly, heterosexual adolescents may experiment with sexual activity with a person of the same sex. It is the adolescent's sexual *activity* that is associated with particular risks, not her/his sexual *orientation.*

High-risk sexual behavior among gay teenagers has remained quite common, despite the threat of HIV infection (Remafedi 1994b; Rosario et al., 1999). In addition, many teenagers engage in sexual activity with partners with whom they are not well acquainted and communicate poorly about HIV and STD protection as well as about pregnancy prevention. Young gay teenagers report using sexual experience as a way to learn about being gay. Unfortunately, unprotected intercourse puts them at high risk for HIV and other sexually-transmitted diseases, such as urethritis, anogenital conditions, oropharyngeal conditions, gastrointestinal disease, hepatitis, and herpes (Table 4.2) (Osmond, Charlebois & Haynes, 1993; Paroski, 1987; Remafedi 1990).

The epithelial surfaces of the rectal mucosa can be damaged readily during anal intercourse, facilitating the transmission of pathogens. Rectal intercourse has been shown to be the most efficient route of infection by hepatitis B, cytomegalovirus, and HIV (Remafedi, 1990). Oral sex may lead to pharyngeal disease and to gonococcal or nongonococcal urethritis. Rates of infection with chlamydia, Epstein-Barr virus type 2, and gonorrhea are rising among gay men (Ciemins et al., 2000; Van Baarle et al., 2000; Xia et al., 2000). Of particular concern is the observation that many of these sexually-transmitted pathogens further facilitate the spread of HIV.

Proctitis is commonly caused by gonorrhea, chlamydia, herpes simplex, syphilis, and human papilloma virus. Proctocolitis is caused by shigella, salmonella, and other intestinal bacteria, and causes abdominal pain, bloody diarrhea, and fever. Enteritis is caused by several intestinal parasites, e.g., giardia and entamoeba histolytica, and causes abdominal pain and diarrhea, bloating, and nausea. Hepatitis A and B and cytomegalovirus are readily transmitted sexually. Despite the availability of an effective vaccine, few young adults are appropriately protected against Hepatitis B (MacKellar, 2001).

Urethritis is most commonly caused by gonorrhea and/or chlamydia. Some dermatologic conditions are sexually transmitted, such as scabies, pediculosis, and venereal warts. Oral pharyngeal lesions may be caused by gonorrhea, or less commonly by syphilis or herpes.

Among lesbian teenagers who *only* have sex with women, the risk of most sexually-transmitted diseases is lower than it is for heterosexual women (White 1997). In any case, though, most adolescent lesbians have had sex with men and thus have exposed themselves to the same risk of sexually-transmitted diseases as heterosexual women have. In addition, of course, they subject themselves to the risk of unintended pregnancy.

Human papilloma virus can be transmitted between women, as can trichomonas, herpes, and chlamydia. Bacterial vaginosis is seen more commonly among lesbian than heterosexual women (Bailey et al., 2000; Fethers, 2000; Marrazzo, 2000). No other gynecologic problems are seen in increased frequency among lesbian teenagers, though the risk of breast cancer is said to be greater among older lesbians. For girls as well as boys, the adolescent's pattern of sexual *behavior* is more important in assessing risks than is sexual orientation.

HIV/AIDS

The age at which infection with human immunodeficiency virus occurs has been declining, with at least 25% of new infections occurring in people under 21 years of age (Gourevitch 1996). Among adolescents, sexual activity between males has been implicated in 50% to 75% of the reported AIDS cases (Abdalian, 1993; deWit, 1996; Povinelli, 1996; Rosenberg, 1994). In a national survey, only three out of five males aged 17 to 19 reported using condoms during their last sexual encounter. Among males with five or more partners or who use injection drugs, condom use was even lower (Centers for Disease Control, 1995).

The current status of the HIV epidemic among adolescent and young adult gay men is of great concern. Recent alarm has led the American Academy of Pediatrics and the American Medical Association to recommend that all providers who work with teenagers include AIDS prevention education as part of *routine* care. The long incubation period from the time of infection to the onset of symptoms has led to underestimation of the full extent of the problem among adolescents. Most young adults who develop AIDS were infected during their teens. Adolescents of racial and ethnic minorities and homeless youth are at particularly very high risk for HIV.

A large multi-site, population-based survey reported the prevalence of HIV infection among gay men to be from 2.2% to 12.1% depending on the site (average 7.2%). The prevalence was much higher among non-white men. Evidence of Hepatitis B infection existed in 11% and of syphilis in 0.7% (Valleroy et al., 2000). Even more alarming data are reported from another multi-city sample. The prevalence was 11% among 18- to 29-year-old gay men and up to 26% in older men (Cantania, Osmond, Stall, Pollack, Paul, Blower, Binson, Canchola, Mills, Fisher, Choi, Porco, Turner, Blair, Henne, Bye, & Coates, 2001)

A large number of adolescents engage in same-sex activity, even though they will not later identify themselves as gay. Thus, the extent of the risk for HIV transmission is even higher than would be expected from prevalence

figures alone. For example, among those with a positive test for HIV at an adolescent AIDS clinic, nine out of ten males reported same-sex intercourse, but only half (54%) identified as gay (Futterman, Hein, Ruben, Dell, & Shaffer, 1993).

Pregnancy

Heterosexual activity is common among lesbian and gay adolescents. Four out of five lesbian adolescents and more than 50% of gay male adolescents reported a history of heterosexual intercourse (Rosario et al., 1994). Among high school students in Massachusetts, 30% of those who were classified as gay, lesbian, or bisexual acknowledged that they had "been or gotten someone pregnant," as compared with 11% of heterosexual students (Blake et al., 2001). Clearly unintended pregnancy is a risk for these teens that could be reduced with appropriate counseling and education.

TRANSGENDER YOUTH (with Norman Spack, M.D.)

Transgender (transsexual) persons are those who maintain a strong and persistent cross-gender identification, not merely a desire for sociocultural advantages of being the other sex. As difficult as it may be for gay and lesbian youths to acknowledge their sexual orientation in a society where gay bashing is all too common, transgender teenagers are confronted by an even greater lack of public understanding and acceptance. Cross-gender or transgender behavior has been documented throughout history and across cultures. The current classification of transgender individuals is Gender Identity Disorder (DSM IV) which includes gender dysphoria (discomfort and distress with one's anatomic gender) and cross-gender identification. Estimates of the size of the teenage transgender population are inherently misleading, since few adolescents are willing to stand up and be counted among such a minority.

Childhood cross-gender behavior is not a predictor of later transgenderism, although most adult transgender individuals report symptoms of gender dysphoria dating back to childhood (Zucker & Bradley, 1995). Young effeminate boys, even those who express unusual interest in female attire, rarely turn out to become either transvestite or transgender adults (Green et al., 1987). On the other hand, if a teenager expresses the desire to be a different gender or dresses routinely in the clothes of the opposite gender, it is less likely to be a passing phase (Money, 1994). Most transgender adolescents typically feel safer remaining androgynous in dress and demeanor.

In many respects, the transgender community faces the same challenges as the gay community of a previous generation, before the era of gay rights and the creation of powerful political advocacy groups and support organizations. Given the public perception of transgenderism as a combination of mental illness and drag queen entertainment, teenagers struggling with issues of gender

identity have few role models other than the flamboyant characters of TV talk shows. Fortunately, the internet has created more possibilities for contacts among individuals and organizations serving the transgender population.

Transgender individuals are severely stigmatized. In one study, approximately 60% reported harassment and violence and 37% various forms of economic discrimination (Lombardi, Wilchins, Priesing, & Malouf, 2001). Drug and alcohol abuse complicate social isolation and underachievement in education and employment (San Francisco Department of Public Health, 1997). Recent analyses report an extremely high rate of HIV infection—up to 35%—among male-to-female transgender persons. In addition, 55 to 62% of transgender adults were found to be clinically depressed and 32% had attempted suicide (Clements-Nolle, Marx, Guzman, & Katz, 2001).

Contrary to common beliefs, female-to-male (FTM) transgenderism may be as common as male-to-female (MTF) transgenderism. FTMs are difficult to identify in western society where dressing androgynously is acceptable and common. Men wearing typically female attire, however, are more noticeable. MTFs are frequently assumed to be gay males who cross-dress and adopt a female persona in an attempt to attract men. This popular notion disregards the fact that transgenderism signifies gender identity, not sexual orientation. In their chosen gender identity, they have the same propensity as anyone else to be heterosexual, homosexual, or bisexual (Cohen-Kettenis & Gooren, 1999).

There are no biochemical/hormonal markers that distinguish transgender individuals, and the origin of gender dysphoria remains unclear (Gooren, 1990). One hypothesis suggests that their brains may be structurally different. Certain hypothalamic nuclei are known to be markedly different in size between men and women. In a postmortem study with a small group of subjects, the nuclei in MTFs were the size typical of genetic females (Kruijver et al., 2000).

Transgender individuals may seek gender reassignment treatments. The process of gender reassignment is long and involves psychiatric, endocrinologic, and surgical components. Hormone therapy precedes any surgical procedures and may itself be associated with various medical risks (Futterweit, 1998).

Because serum hormone levels in gender-dysphoric individuals are consistent with their genetic sex, there is a tendency to withhold hormonal treatment until patients have experienced the full effects of their genetically and gonadally-determined puberty. This approach evolved because it is so difficult to be predictive about adolescents. There is also a tendency to assume that the appearance of the expected secondary sexual physical changes will steer the uncertain person towards a gender identity consistent with the body that has developed. These physiologic changes, however, may be psychologically devastating for the transgender teen. The manifestations of gender in an FTM, i.e., breast development and menses, may result in profound depression and recurrent (sometimes monthly) cycles of self-mutilation and suicidal gestures. In the MTF the presence of a beard, a bulging adam's apple, increased muscle mass, and the broadening of hands and feet are particularly disconcerting. Many MTFs are destined to undergo years of expensive and time-consuming electrolysis because of the effects of endogenous androgens on their hair follicles.

In North America, few patients have received hormonal treatment under a physician's care prior to age 18. By that time androgen's effects on beard growth and body habitus are well established. In the Netherlands, where transgenderism is a more accepted phenomenon and recognized in academic medical centers, carefully evaluated adolescents may be given an opportunity to suppress pubertal manifestations via the administration of gonadotrophin-inhibiting GnRH analogues (Cohen-Kettenis & van Goozen, 1998; Gooren & Delemarre-van de Waal, 1996). A kind of limbo, a profound delay in pubertal maturation, is thus created without creating permanent physical changes. Upon reaching legal age, these teens can then authorize treatment with the hormones of choice to induce desired changes in the larynx, hair follicle, or breasts. At the age of eighteen, they may be considered candidates for irreversible surgery on breasts and genitals.

Treatment of the teenager experiencing gender dysphoria should begin with an assessment by a mental health clinician experienced with the condition. Only after the counselor has deemed the patient eligible for hormonal replacement therapy (HRT) should referral be made to an endocrinologist or other physician experienced with the various therapeutic options. A decision to intervene hormonally requires approval by the parent or guardian unless the patient is an emancipated minor.

The goals of HRT in FTMs include suppression of menses and maintenance of testosterone levels in the normal male range. Doses of testosterone typically used for hypogonadal males will achieve these goals within a few months. Oral androgens are not recommended due to the risk of liver damage from these methylated compounds. In MTFs, the goal is to reduce the level of testosterone and to blunt its peripheral effects. The latter is usually achieved with daily doses of spironolactone, which reduces the thickness and growth rate of androgen-stimulated hair within 3-6 months. Suppressing endogenous testosterone levels in the presence of functioning testes requires supraphysiologic doses of estrogen often with added progesterone to achieve maximal breast development. This hormonal milieu creates the potential for thromboembolic phenomena, particularly for individuals with higher risk, such as smokers, and does increase the risk of later breast cancer far above that observed in nontransgender males (Orentreich & Durr, 1974).

The ultimate goal for most MTFs is feminizing genitoplasty or "SRS" (sex reassignment surgery), an expensive procedure performed by relatively few surgeons and rarely covered by insurance policies. Some patients temporize with a relatively inexpensive bilateral orchiectomy, reducing or eliminating the need for androgen receptor blockers such as spironolactone and permitting estrogenization and reduction of testosterone levels using physiologic doses of estrogen.

Relatively few FTMs seek genital surgery, because the phallic structure created is more cosmetic than functional. Clitoral length increases after two-three years of androgen treatment to an average of four centimeters. Since breasts remain their most public expression of femaleness, most FTMs seek the services of a surgeon experienced in the unique mammoplasty capable of giving them a male chest. For obvious reasons, surgeons will not consider

operating until experienced counselors and treating physicians have deemed the patient an appropriate candidate.

The Harry Benjamin International Gender Dysphoria Association, a multidisciplinary society dedicated to disseminating knowledge and preventing exploitation of transgender individuals, has established a set of "standards of care." For example, a patient has to have lived in the desired gender for at least a year before undergoing surgery.

The rare transgender high school student who decides to attend school with a new name and attire presents a special challenge for the school community. Administrators, nurses and teachers encounter many issues ranging from avoidance of harassment to gym assignment and bathroom use. Many transgender students will wait until they move into an entirely new environment before expressing themselves in their chosen gender, and residential college may present the first such opportunity. This decision poses a challenge for university administrators who have sent a letter of acceptance to someone with a different name and gender from the person who arrives on campus. A student, particularly an MTF, is unlikely to have initiated the process of physical transition leading to the desired "gender attribution." Since the prospect of living in a freshman dormitory with randomly-selected female roommates is unacceptable, a single room may be the optimal option. An FTM, however, particularly one who exhibits the effects of having begun androgens and who has had reduction mammoplasty, may find less difficulty blending into a male roommate situation. Some colleges and universities have been supportive of the needs of their transgender students, offering the full range of health services including the provision of oral and injected medications and PAP smears for FTMs. As colleges are increasingly committed to student diversity, some do provide support services, counseling, and organizations for individuals who represent the full spectrum of gender identification.

Transgender people face significant discrimination in employment, housing, and access to health care. MTF individuals are especially likely to be targets of verbal and physical abuse. Organizations of gay and lesbian students have been among the most public advocates for transgender individuals (Lombardi, 1999). The American Public Health Association published recently a policy underscoring the need for acknowledging transgender individuals in all health care contexts (APHA Policy Statement 9933, 2000). Child health professionals can assist adolescents who consider themselves transgender by ensuring a safe environment, providing information about community and national resources, and enforcing policies regarding confidentiality and nondiscrimination (Lombardi, 2001).

ATTEMPTS AT CONVERSION

Prior to the recognition of homosexuality as a normal variation of human sexual experience, various "therapeutic" methods were used to change people's attractions from homosexual to heterosexual. The various forms of

"reparative" therapies are based on the outdated belief that homosexuality is *intrinsically* pathological rather than the more current view that it is the force of social stigma that creates distress for people of homosexual orientation.

While some such efforts continue (Nicolosi, 2000), they are controversial and may be associated with significant negative outcomes (Haldeman, 1991; Stein, 1996). The American Academy of Pediatrics has stated that "therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in sexual orientation" (American Academy of Pediatrics, 1993). The American Psychiatric Association concurs, stating that "there is no evidence that any treatment can change a homosexual person's deep-seated sexual feelings for others of the same sex" (American Psychiatric Association, 1994).

Many professional organizations have stated explicitly that the change necessary is in societal attitudes and behaviors, not in individuals' sexual orientation. They have called, for example, for "the enactment of civil rights legislation at local, state, and national levels that would offer homosexual citizens the same protections now guaranteed to others" (American Psychiatric Association, 1994); for "the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private" (American Psychological Association, 1991); and for "the elimination and prevention of discriminatory statutes, policies, and actions that diminish the quality of life for lesbian and gay people and that force many to live their lives in the closet" (National Association of Social Workers, 1992).

ADOLESCENT HEALTH CARE

For all adolescents, the overall goal of health care is to promote normal adolescent social and emotional development, wellbeing, and physical health. The purpose of a careful sexual history is to assist the adolescent and the professional to understand sexual concerns, risks, and indicated interventions, not to assign a sexual orientation. *All* adolescents will benefit from honest and supportive discussions about sexual orientation and sexual behavior (Rawitscher, Saitz, & Friedman, 1995). Many who are certain about their own sexual orientation may have a friend, teacher, or relative who is gay or lesbian or who is struggling with her/his sexual orientation. A trusting relationship between teenagers and their health care providers is the basis for effective communication.

The American Academy of Pediatrics' policy statement, "Homosexuality and Adolescents," stated that "the physician's responsibility is to provide comprehensive health care and guidance to all adolescents, including gay and lesbian adolescents and those young people struggling with issues of sexual orientation. Pediatricians who care for teenagers need to understand the unique medical and psychosocial issues facing homosexually-oriented youths" (AAP, 1993). The revised and updated policy statement to appear next year will reiterate and expand further on pediatricians' responsibilities to gay and lesbian youth and their families.

Meetings with teenagers without parents present, explicit reassurance and explanations of the limits of confidentiality, and care in recording private information in charts and in letters of referral will facilitate adolescents' sense of safety with their health care provider. First and foremost, providers must learn new ways to ask questions about sexual behavior and sexual orientation that do not assume heterosexuality, ask the same questions of all adolescents, and refrain from making assumptions about an adolescent's behavior or sexual orientation on the basis of appearances or social stereotypes.

All adolescents, gay or not, worry about and may experience disapproval and stigmatization in medical settings. Assurance and repeated reminders of policies regarding confidentiality, and visible indications of acceptance and knowledge about homosexuality, will help them to confide in primary care clinicians about the whole range of their concerns and health care needs. By providing information about community networks of support, books, and internet contacts, clinicians further reinforce their availability as a resource for these adolescents and their families. A sampling of resource materials is provided in Chapter 7.

EXPANDED PEDIATRIC RESPONSIBILITIES

Most adolescents would like to "come out" to their parents and siblings, to be fully known and shed the need to maintain an awkward secret. Fear of rejection and disapproval may restrain some teens, especially if they have not yet developed a supportive network of peers and adults. Self-esteem and positive adolescent adjustment are enhanced for most adolescents after "coming out," especially if the process is managed with sensitivity and understanding of its likely impact. An important contribution health care providers can make is to encourage teenagers to "come out" to their parents and siblings and to help them plan an appropriate time and process to do so.

After a teenager "comes out" to his/her parents, they often experience powerful feelings of guilt and shame and may benefit also from advocacy and support from health care professionals. Parents have been described as advancing through a series of stages in the awareness and acceptance of their child's homosexuality (Strommer, 1993). These stages are described as (1) *subliminal awareness* when the child's gay identity is inspected; (2) *impact* when the gayness is discovered or disclosed; (3) *adjustment* when the family denies the homosexuality or attempts to keep it a secret; (4) *resolution* when the family mourns the loss of the anticipated heterosexual identity, and (5) *integration* when new relationships are established based on new understanding.

Siblings, grandparents, and other family members probably experience a similar process in recognizing and adjusting to a teenagers' homosexuality, though it is less influenced typically by guilt and self-criticism. No research has focused on the possibly protective roles that siblings, grandparents, aunts, and uncles might play in helping adolescents to disclose their homosexuality to their parents.

Families of a gay or lesbian adolescent may anticipate and/or experience the isolation and disapproval of "second-hand stigma" or "stigma by association" (Goffman, 1963). It is unfortunate when families try to hide the presence of their gay or lesbian adolescent, keeping the information secret from other family members, neighbors, and colleagues. Keeping a secret about something of such long-term significance to the family is bound to be toxic to intra- and inter-familial relationships and will not be interpreted by the teenager as unconditionally supportive of her/his emerging identity and further development.

Primary care clinicians can help families to gain information and to confront their discomfort with their adolescent's disclosure of homosexuality. The growing number of publications, websites, and community support networks such as PFLAG may make the transition to full acceptance easier (Chapter 7). Most parents report improved relationships with the adolescent after disclosure (Borhek, 1988; Boxer et al., 1991). For families who have greater difficulty accepting their adolescent's homosexuality, a colleague trained in family therapy may be able to facilitate a more constructive dialogue.

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Children Whose Parent(s) Is/Are Lesbian or Gay

Unanswered questions are far less dangerous than unquestioned answers

A growing number of children are being brought up by one or more gay and/or lesbian parents in one of a variety of family constellations. Legitimate curiosity and concern about the well-being of these children and their families—as well as a response to stigmatization and legal disenfranchisement—have led to increasing research and an accumulating body of knowledge to inform their care.

PATHWAYS TO PARENTHOOD

Accurate statistics regarding the number of parents who are gay or lesbian are impossible to obtain. The secrecy required as a result of the stigma still associated with homosexuality has hampered even basic epidemiological research. Data collected by the National Health and Social Life Survey (Laumann, 1995) suggest that there may be between 800,000 and 7 million lesbian and gay parents between 18 and 59 years old, and among them between 1.6 and 14 million offspring. Of these, somewhere between 1 million and 9 million are less than 18 years of age, representing between 1 and 12 % of children in the US. These broad ranges reflect different survey methods: the lower numbers are based on individuals who identified themselves as lesbian or gay on the survey instrument, while the higher numbers reflect anyone who reported interest in a same sex relationship (Stacey & Biblarz, 2001).

Most people who have a lesbian and/or gay parent were conceived in the context of a heterosexual relationship. Current estimates suggest that up to

5 million lesbian women have borne one or more children while in heterosexual relationships (Falk, 1989; Gottman, 1989). Undoubtedly there have always been children whose mother or father, or both, recognized that they were lesbian or gay some time after being married. In one study, 31% of men and 74% of women were unaware of their homosexuality when they married (Wyers, 1987). Others marry in spite of their recognition that they are gay. Their reasons for marrying include love for the spouse, desire for a long-term, intimate relationship, and the hope of a 'cure' for their homosexuality. Some marry in order to have children, and others may think of themselves as bisexual. Marriage is not (yet) possible for two adults of the same gender. 'Civil unions' such as have been introduced recently in Vermont provide for lesbian and gay couples a legally-sanctioned commitment and some of the associated financial and social benefits of marriage.

When one or both parents in a heterosexual couple "come(s) out" as lesbian or gay, some parents divorce and others continue to live as a couple. If they do decide to live separately, either parent may be the residential parent, or children may live part-time in each home. Gay/lesbian parents may remain single or they may have same-sex partners who may or may not develop step-parenting relationships with the children. The variety of family constellations adopted by these families resembles closely the step-families formed by heterosexual couples after divorce, and many of their parenting concerns and adjustments are similar (Wyers, 1987). Special concerns arise from the uncertainty of social approval for lesbian and gay parenting and the pervasively heterosexist legal precedents that have resulted in denial of custody and restriction of visitation rights to many gay and lesbian parents (Benkov, 1994).

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

Many of the same concerns that exist for heterosexual couples when they consider having children also face lesbians and gay men. All parents have concerns about time, finances, and the responsibilities of parenthood. They worry about how children will affect the couple relationship, their own and their children's health, and about their ability to manage their new parenting role in addition to their other adult roles. Lesbians and gay men undertaking parenthood face additional challenges in conceiving or adopting a child. They face, for example, decisions about where to obtain donor sperm; arranging for a surrogate; ensuring the health of donor or surrogate; making legally binding arrangements regarding parental relationships; finding an accepting adoption agency; creating a substantive role for the non-biological, non-adoptive parent; and confronting the pain and restrictions imposed by heterosexism and discriminatory regulations (Benkov, 1994; Parks & Hamilton, 1991).

In contrast to heterosexual couples contemplating parenthood, gay men and lesbians do not face society's expectation that they will have children. Indeed, they may face disapproval for their choice to become parents. Historically, 'gayness' and 'parenthood' have been seen as mutually exclusive. These beliefs endure despite the increasing number and visibility of parents who are openly lesbian or gay because "the same-sex family, more than any other form, challenges fundamental notions of family and gender relationships (Laird, 1993). Some couples may believe that their decision must be kept secret, creating further emotional struggles. For some, internalized homophobia has created doubts about their parenting legitimacy and/or competence.

Despite these challenges, lesbian women and gay men increasingly are becoming parents on their own or in the context of an established same-sex relationship. Conservative estimates suggest that the parent(s) in at least 5,000–10,000 families bearing children in the U.S. now are lesbians (Seligman, 1990). The majority of lesbian women who conceive a child do so using alternative insemination techniques with a donor's sperm. The woman/women may choose to become pregnant using sperm from a completely anonymous donor, from a donor who has agreed to be identifiable when the child becomes an adult, or from a fully-known donor (e.g. a friend or relative). While regulations and laws differ among the states of the United States and among other countries, women seeking donor insemination often face legal, political, and informal policies that encumber their ability to arrange for appropriate services. Lesbian women can become parents as well by fostering or adopting children—as can gay men. These opportunities are increasingly available in most states of the United States and in many other countries, though they are still limited by legal statutes in some places, in most states and in most countries, lesbian and gay couples are not permitted to adopt a child *together* in the same way that heterosexual couples can, i.e. only one partner can become the child's legal parent at the time of adoption.

Growing numbers of gay men have chosen to become fathers through the assistance of a surrogate mother who bears their child. Others have made agreements to be co-parents with a single woman (lesbian or heterosexual) or a lesbian couple (Barret & Robinson, 1990; Bigner & Bozett, 1990; Patterson & Chan, 1996). Still other men make arrangements to participate as sperm donors to the conception of a child (frequently with a lesbian couple), agreeing to have variable levels of involvement with the child(ren) but without taking on the responsibilities of parenting.

This intentional development of families by lesbian and gay couples challenges entrenched beliefs about the nature of a 'normal' family, as well as about the range of family structures that is compatible with the healthy development of children. Research investigating the experience of children who are part of these new family forms is in early phases.

Typical stereotypes about homosexuality do not match up well with those of the idealized parent who is endlessly nurturing, warm, and selfless. Gay men are imagined to be frivolous, irresponsible, and often immoral (especially with regard to sexuality); lesbians to be cold, driven and aggressive; same-sex relationships are thought of as transient and hedonistic. Gay men are faced

with an especially difficult dilemma in taking on a parental role because adult males are still expected to fulfill primarily an occupational role and to relegate parenting to secondary status. Combined with social stereotypes of gay men as avoiding accountability, gay fathers indeed face a role under pressure (Bigner & Jacobsen, 1989a). Considerable suspicion surrounds the notion of fathers taking on primary parenting responsibility, and mothering remains a more acceptable role than fathering. A poignant description of coming to terms with this dilemma can be found in *The Velveteen Father: an unexpected journey to parenthood* by Jesse Green (1999).

Lesbian mothers and gay fathers report feeling somewhat marginal to both their lesbian/gay community of friends who are not parents, and to the heterosexual parents who are their neighbors and friends (Williams, 1995). Many identify themselves more closely with the latter because of their shared commitment to parenting (Hare, 1994). Supportive relationships with their families of origin may provide an important buffer from discrimination and social isolation for gay parents and their children. In addition, a rich network of friends serves many families as supporters, advisers, and role models for their children (Koepke, Hare, & Moran, 1992).

Committed parents who have no biological or legal (adoptive) relationship with the child(ren) are in an especially ambiguous position. The nonbiological mother may experience some distress in not being acknowledged as a prospective parent during the pregnancy and after the delivery, and may feel anxious about the child's early bonding with her (McCandlish, 1987). The partner of a lesbian woman who conceives their child has neither a genetic link nor the physiological and psychological experiences of pregnancy on which to base an immediate maternal relationship with the child. She also receives no legal standing as the child's parent.

When a lesbian woman or a gay man becomes a parent through alternative insemination or adoption, she/he is recognized within the legal system as having full and more or less absolute parental rights. The biological/adoptive parent's partner, though, has no formal legal rights with respect to the child despite functioning as a co-parent. Most state laws do not allow for adoption or guardianship by an unmarried partner unless the parental rights of the first parent are terminated. An attorney can prepare medical consent forms and nomination-of-guardian forms for the care of the child(ren) in the event of the legal parent's death or incapacity. These documents, however, do not have the force of an adoption or legal guardianship, nor the guarantee that a court will uphold them. Some states recently have passed legislation that allows coparents to adopt their partner's child(ren). Other states have allowed their judicial systems to determine eligibility for formal adoption by the co-parent on a case-by-case basis. The American Academy of Pediatrics supports co-parent (or second-parent) adoption because of its psychological, financial, and legal benefits to the child (American Academy of Pediatrics, 2002).

The legal sanction provided by coparent adoption guarantees that the second parent's custody rights and responsibilities will be protected if the first parent were to die or become incapacitated. In the absence of coparent

adoption, members of the legal parent's family of origin might successfully challenge the surviving coparent's rights to continue to parent the child, thus causing the child to lose both parents. Similarly, coparent adoption establishes the requirement for child support from both parents in the event of the parents' separation and protects the second parent's rights to custody and visitation, thus protecting the child's right to maintain a continuing relationship with both parents. Legalized adoption also ensures the child's eligibility for health and other appropriate entitlements, such as Social Security survivor's benefits from both parents, and 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. Several legal decisions have advocated for these benefits (Delong, 1998; Boswell, 1998).

In addition to the legal security of co-parent adoption, couples who wish to share parenting have found various ways to establish and validate that relationship. Some examples include utilizing a relative of the non-conceiving mother as the sperm donor (thus creating a genetic link to both mothers) and/or giving the child the non-biologic mother's last name. For some couples, sharing the maternity leave has allowed both mothers to develop a close early relationship with their infant. Stiglitz (1990) found that first-time lesbian mothers were more dissatisfied with the level of affection and intimacy in their relationships with partners and the level of their connections to their families of origin than were first-time heterosexual mothers. On the other hand, lesbian couples have been found to share household and child care tasks more equitably than do heterosexual couples (Gartrell, Banks, Hamilton, Reed, Bishop, & Rodas, 1999; Kurdek, 1993; Mitchell, 1996; Patterson, 1995c; Sullivan, 1996).

The complexity of possible parenting arrangements means that the term "children who have a gay or lesbian parent or parents encompasses a huge range of family experience. A child may have been born or adopted into a family consisting of two committed partners of the same sex, or by a single gay man or lesbian woman. Alternatively, a child might have been born to heterosexual parents and may have experienced the break-up of that relationship. In that case, the child may have one or two parents who have new partners, who may be of the same sex or the opposite sex. Differing amounts of collaboration and sharing of child-rearing responsibilities characterize all such "reconstituted" family constellations. Systematic research is hampered by the important differences these varied family forms are likely to make for the children, along with the other restrictions on adequate sample recruitment discussed earlier.

RESEARCH DIRECTIONS

Gay fathers and lesbian mothers have been prevented from becoming foster parents or adopting children, and have been denied custody of their children in the event of divorce, on the grounds that they would not be effective parents. Legal justifications and social beliefs have presumed that their children would experience stigmatization, poor peer relationships, subsequent

behavioral and emotional problems, and abnormal psychosexual development. Over the past 20 years many investigators have tried to determine if there is any empirical support for these assumptions. Concern about potential sexual abuse of children by gay parents has been put to rest by epidemiologic data. The large majority of sexual abuse of children is perpetrated by heterosexual men (Jenny, Roesler, & Poyer, 1994).

The well-being of children raised primarily by a single homosexual parent or by a same-sex couple raises interesting questions as well about prevalent beliefs regarding the importance to children's psychological development of having a parent of each sex. Psychodynamic theories of child development maintain that children relate quite differently to their mothers and their fathers, and that the resolution of conflicts between these different relationships result in healthy psychological development. Social learning theory also posits that children learn different lessons from male and female parents, and that both are necessary for healthy development and socialization. Fathers are expected to model and reward masculine behavior in their sons and mothers to demonstrate and cherish feminine behavior in their daughters. If one of these models is missing, children are presumed to be at risk. Empirical investigations of children whose parents are gay or lesbian have systematically challenged these assumptions. I will describe first the approaches taken to studying these issues systematically, and some of their limitations. Then in the following section I will present a summary of the findings this research has begun to yield.

Samples available for these studies have been limited in size and heterogeneity, generally including primarily highly-educated, urban, Caucasian, middle-class individuals who have had sufficient support and resources to accept and to risk public recognition of their homosexuality. The accumulated evidence, therefore, cannot yet be generalized to a more broadly representative population of lesbian and gay parents and their children. In addition, a dearth of instruments available to document meaningful and long-term outcomes hampers research on the effects of various parenting choices.

Ideological pressures have constrained scientific investigation into better understanding of the ways in which particular family constellations, including one or more gay or lesbian parents, affect their children. Because of the need to protect themselves against pervasive social and legal threats, most of the research about lesbian and gay parents seeks to provide evidence that these parents do not cause harm to their children. Comparisons between children whose parents are heterosexual and those who are not have repeatedly demonstrated no evidence of differential risk. The question itself presumes heterosexual parents to be the "gold standard" and focuses on whether children of non-heterosexual parents are in some way "defective."

The focus of most research regarding children with gay or lesbian parents has been on four main *topic areas.* Investigators have concentrated on describing (1) the attitudes and behaviors of the parents, and the (2) psychosexual development (and sexual orientation), (3) social and interpersonal experience, and (4) psychological/emotional status of their children. Investigations have

taken three primary *forms:* (a) comparisons of divorced lesbian and heterosexual mothers; (b) qualitative studies of children with divorced gay fathers; and (c) studies of children born to or adopted by lesbian mothers. In addition, anecdotal reports have been gathered from children whose parents are lesbian or gay (Rafkin,1990; Saffron, 1997), and from the parents themselves (Dunne, 1998; Pollack & Vaughn, 1987). Several approaches to this research are summarized below, followed by a summary of their salient results.

a. Studies of Previously-Married Mothers

Many investigators have studied the general psychological functioning, attitudes, and interests of lesbian and heterosexual mothers. Almost all are cross-sectional surveys based on small non-random samples including mostly Caucasian, urban, well-educated participants who had their children in the context of heterosexual marriages and are relatively accepting of their homosexuality. Most of these studies have compared divorced lesbian and heterosexual mothers and the children of each (Golombok, Spencer, & Rutter, 1983; Gottman, 1989; Green, Mandel, Hotvedt, Gray, & Smith, 1986; Harris & Turner, 1986; Javaid, 1993; Miller, Jacobsen, & Bigner, 1981; Pagelow, 1980; Tasker, 1995). These two types of families are alike in that the children share the experience of parental separation and divorce, and that they are being raised by women without the daily presence of a father, but differ in the sexual orientation of the mother. Many such studies fail to ascertain the subsequent repartnering experience of the mothers and thus to control for single-parent status. They also fail, in general, to take into consideration the nature of the relationship between the former spouses and the extent and nature of the children's relationship with their father. Both of these factors are well known to contribute powerfully to children's adjustment and coping after their parents' divorce (Cummings & Davies, 1994; Emery, 1982; Hetherington, 1989).

Most of these studies use a cross-sectional design and present data about young children or early adolescents. To investigate the possibility that psychosocial difficulties might appear during adolescence or adulthood that had not been evident earlier, Tasker and Golombok organized a followup study of adults who had been raised after divorce by a lesbian mother. The sample consisted of 25 young adults whose mothers were lesbian (8 men and 17 women) and 21 young adults whose mothers were not (12 men and 9 women). At the time of follow-up, these children were 17 to 35 years of age (Golombok & Tasker, 1994; Golombok, Tasker, & Murray, 1997; Tasker, 1995; Tasker & Golombok, 1997).

b. Studies of Gay Fathers

Research addressing how children fare when their father is gay has been largely descriptive (Bailey, Bobrow, Wolfe, & Mikach, 1994; Bigner & Bozett, 1990; Bozett, 1981, 1989; Harris & Turner, 1986; Patterson & Chan, 1996), and includes very small samples. One study compared 33 homosexual and

33 heterosexual fathers who each had at least two children with a mean age of 11 years at the time of the study (Bigner & Jacobsen, 1989a). They compared fathers' responses to the Iowa Parent Behavior Inventory, which yields reports of fathers' active involvement with children, setting and enforcing limits, responsiveness to children's expressed needs, guidance and support of emotional needs, and physical affection/intimacy with the child. Another study by the same authors (Bigner & Jacobsen, 1992) compared parenting styles and attitudes among gay and non-gay fathers. Still another compared parenting of gay fathers to that of lesbian mothers (Bozett, 1985). Few fathers—gay or not—have primary custody and parenting responsibility for their children after divorce, and no studies yet examine gay fathers parenting alone. Therefore, the data available reflect primarily on the roles assumed by divorced fathers parenting in a non-residential capacity. A recent survey of 101 gay fathers in the United Kingdom provides information about their routes to parenthood, their partners' involvement with parenting, successes in meeting common parenting challenges, and their children's responses to the experience of growing up with a gay parent (Barrett & Tasker, 2001).

c. Studies of Children Born To or Adopted By Lesbian Mothers

The earliest studies of children born to lesbian women addressed the process of separation-individuation among preschool children. Children born after alternative insemination using an unknown donor were compared to those whose parents were heterosexual (McCandlish, 1987; Steckel, 1987). A cross-sectional study reported on aspects of the social and personal development of 15 children born to lesbian couples and 15 children from matched two-parent heterosexual families (Hand, 1991; Osterweil, 1991).

Several research groups subsequently have examined the social and personal development of children in families formed by same-sex couples. The Bay Area Families Study has collected data from a convenience sample of 37 families with a child aged 4 to 9 in the home who had been born to or adopted by a lesbian mother or mothers. In 26 of the 37 families, a lesbian couple were co-parents; 7 mothers were living alone with their children, and in 4 families the lesbian co-parents had separated and the children were cared for in a joint custody arrangement (Patterson, 1996, 1997, 1998).

The British Longitudinal Study is attempting to ascertain the developmental outcomes for children in a variety of different family structures (Tasker, 1999; Tasker & Golombok, 1998). The investigation includes 30 children from 3 to 9 years old whose mother identified herself as lesbian before the child was born, 42 children of single heterosexual mothers, and 42 children with two heterosexual parents. Standardized interview and questionnaire measures assessed the quality of the parenting and the socioemotional development of the children.

Several recent longitudinal studies have undertaken an investigation of children's adjustment and parental relationships in families created using anonymous donor insemination. In the Contemporary Families Study, 34 families

were headed by lesbian couples, 21 by lesbian single mothers, 16 by heterosexual couples, and 9 by heterosexual single mothers. At the time of the most recent publication, the children were 7 years of age (Chan, Raboy, & Patterson, 1998). The European Study of Assisted Reproduction includes 30 lesbian mother families with 4- to 8-year-old children created as a result of donor insemination, 38 heterosexual families with a DI child, and 30 heterosexual families who had a naturally-conceived child. A variety of assessment measures, including a standardized interview and questionnaires from the parents and psychological testing of the child, were used to collect the data (Brewaeys, Ponjaert, van Hall, & Golombok, 1997). The National Lesbian Family Study is a longitudinal investigation of 84 mothers and their children born after anonymous donor insemination (Gartrell, Hamilton, Banks, Mosbacher, Reed, Sparks, & Bishop, 1996; Gartrell et al., 1999; Gartrell, Banks, Reed, Hamilton, Rodas, & Deck, 2000).

d. Voices of the Children

Several authors have provided interviews and essays in which children whose parents are gay or lesbian describe their experience (Hayes, 1995; Lewis, 1980; Rafkin, 1990). A systematic collection of 18 interviews conducted by Lisa Saffron (1997) addresses children's social relationships, sexual orientation, relationship with their mother(s), and their perceptions of their own childhood experiences. Several report increased tolerance for difference and valuing of divergent viewpoints as advantages of growing up with a lesbian or gay parent. Several investigations report on children's experience of teasing or isolation as a result of stigmatization (Golombok et al., 1997; O'Connell, 1993; Tasker & Golombok, 1997; Wyers, 1987). One report describes adolescents' perceptions of ostracism on the basis of their parents' sexual orientation (Gershon, Tschann, & Jemerin, 1999).

FINDINGS OF RESEARCH

Attitudes, Personality, and Adjustment of Parents

Often addressed in the literature is the question of whether lesbian mothers and gay fathers are somehow different from heterosexual parents in ways that might be important to their children's well-being. Stereotypes and laws that maintain discriminatory practices are based on the assumption that these parents/families are deficient or defective in some way. Most research has aimed to question this assumption; no systematic investigation has yet addressed what special resources or coping strategies these new family forms might provide to their children.

Fathers. Gay fathers have a particularly difficult stereotype to overcome. Typically, gay life is thought of as singles-oriented. *Gay men* are seen as having few long-term commitments to partners, few financial obligations, and

a focus on personal freedom and autonomy. *Fathers,* on the other hand, have financial and emotional responsibilities to others, time restrictions, joint living arrangements, dependent children, and so forth. Thus, they hold two social roles that are to some degree seen as inconsistent. They may be marginalized by both the gay community—because of their investment in their fathering responsibilities, and in activities that focus on fathers and their children, like sports or school groups—because they are gay.

Early studies found no differences between gay and non-gay fathers in problem-solving, in providing appropriate recreation for children, in encouraging autonomy (Scallen, 1981), or in dealing with general problems of parenting and discipline (Miller, 1979). Gay and non-gay fathers endorsed a similar active, caretaking stance regarding their paternal role. Gay fathers valued less traditional paternal roles than did heterosexual fathers, ascribing greater importance to nurturing activities and less to economic success. Gay fathers also provided a more positive assessment of their success as fathers than did the heterosexual fathers (Bigner & Jacobsen, 1989b).

Other studies have described fathers' encouragement of gender-appropriate toys, their attempts to provide a female role model for their children, and their children's generally accepting reactions to knowledge of their father's homosexuality (Bailey et al., 1995; Bozett, 1985; Harris & Turner, 1986; Scallen, 1981). Gay fathers have been described repeatedly as nurturing and as having positive relationships with their children (Harris & Turner, 1986; Wyers, 1987). Fathers who had publicly identified themselves as gay were found to be better adjusted, more responsive to their children, and less likely to use corporal punishment, than gay fathers who remained closeted (Bozett, 1987).

More recently gay fathers have described themselves as adhering to stricter disciplinary guidelines than did heterosexual fathers, emphasizing guidance, the development of cognitive skills, and involvement in their children's activities. Gay fathers were more likely to acknowledge greater expressiveness as part of their parenting behavior than were the heterosexual fathers {Bigner & Jacobsen, 1992). More similarities than differences appear to exist in parenting styles and attitudes toward parenting among fathers who are gay or not (Bozett, 1987).

The most recent survey of gay fathers and their children reports that over 60% of the children knew of their father's homosexuality by the age of 11, and documents a wide range in children's level of support and comfort with having a gay father. Fathers reported that their children felt shocked, angry, guilty, and confused in learning about their homosexuality, and many reacted relatively unsupportively. Daughters tended to respond more positively than sons. On the other hand, fathers expected that their children would eventually consider it an advantage to have a gay dad for several reasons, including being more tolerant of other people, providing new points of view, and greater capacity for open conversation. These fathers reported relatively few difficulties they were aware that their children had experienced related to having a gay father. The areas rated as most problematic were tension due to having to keep a secret, being teased or bullied by other children, and feeling different (Barrett & Tasker, 2001).

Mothers. Many investigators have compared lesbian and heterosexual mothers' self-esteem, psychological adjustment, and attitudes toward child-rearing. Few differences have been found over two decades of research (Bigner & Jacobsen, 1992; Green et al., 1986; Harris & Turner, 1986; Kweskin & Cook, 1982; McNeill, Rienzi, & Kposowa, 1998; Miller et al., 1981; Pagelow, 1980; Parks, 1998; Rand, Grahan, & Rawlings, 1982). Lesbian women, whether or not they are mothers, are at no greater risk for psychiatric disturbance than are heterosexual women (Bell, Weinberg, & Hammersmith, 1981; Golombok et al., 1983). Lesbian mothers fall within the range of normal psychological functioning based on interviews and psychological assessments (Rand et al., 1982) and report scores on standardized measures of self-esteem, anxiety, depression, and parenting stress indistinguishable from those reported by heterosexual mothers (Golombok, Cook, Bish, & Murray, 1995). Lesbians who are more open about their lesbianism report higher levels of psychological well-being (Rand et al., 1982).

Several investigators have demonstrated that lesbian mothers strongly endorse child-centered attitudes and commitment to their maternal roles (Benkov, 1994; Bigner & Jacobsen, 1989a; Gartrell et al., 1996; Golombok et al., 1995; Kirkpatrick, 1987; McNeill et al., 1998; Miller et al., 1981). Others have reported that lesbian mothers are even more concerned than are divorced heterosexual mothers to provide male role models for their children (Harris & Turner, 1986; Kirkpatrick, Smith, & Roy, 1981), and encourage their children to see their fathers more frequently after divorce than do heterosexual mothers (Golombok et al., 1983). Lesbian mothers have been reported to have greater knowledge of child development and more successful parenting skills than did the heterosexual comparison group (Brewaeys et al., 1997; Flaks, Ficher, Masterpasqua, & Joseph, 1995; McNeill et al., 1998). Lesbian and heterosexual mothers describe themselves similarly in marital and maternal interests, current life-styles, and child-rearing practices (Kirkpatrick et al., 1981). They also report similar role conflicts, social support networks, and coping strategies (Benkov, 1994; Gartrell et al., 1996; Patterson, 1995a,b; 1998).

More recently, lesbian mothers who had conceived a child using an anonymous sperm donor reported positive self-esteem and psychological adjustment well within the normal range (Flaks et al., 1995). They did not differ from the heterosexual comparison group of mothers in their self-esteem, evidence of depression, or relationship satisfaction. Lesbian couples seem to share child care tasks more equally than heterosexual parents (Chan, Brooks, Raboy, & Patterson, 1998; Gartrell et al., 1999; Patterson, 1995c), though the biological or adoptive mother generally reports taking more responsibility for child care than the co-parent. Over 60% of the families in the Bay Area Family Study report having regular contact with at least one grandparent, and most also have regular contacts with other adult relatives (Allen, 1995; Patterson, Hurt, & Mason, 1998).

The roles and well-being of non-biologic co-mothers have received little investigation until recently. A recent analysis compared their role in 15 families led by lesbian couples to the role of resident fathers in two groups of

heterosexual families (43 in which the child was conceived through donor insemination and 41 in which the child was naturally conceived). Fathers and co-mothers had similarly warm and affectionate relationships with their 3- to 9-year-old children in all three groups, and parenting stress was rated similarly among the three groups of parents. Co-mothers played a more active role in daily caretaking than did most fathers. Fathers in the families created using donor insemination reported more involvement than did the other group of heterosexual fathers, but less than the co-mothers in lesbian couples. Sixty percent of lesbian-led families reported a joint or coordinated policy on disciplining their son or daughter, compared with 22% of heterosexual families with a naturally-conceived child and 23% of heterosexual families with a child conceived through donor insemination (Tasker & Golombok, 1998). Others have demonstrated that co-mothers often have greater knowledge about parenting practices than do fathers (Flaks et al., 1995) and are more involved with their children's day-to-day activities (Brewaeys et al., 1997; Golombok, Brewaeys, Cook, Giavazzi, Guerra, Mantovani, van Hall, Crosignani, & Dexeus, 1996).

A comparison of mothers who had identified themselves as lesbian before the child was born, single heterosexual mothers, and married mothers yielded no differences in reported parenting stress, maternal anxiety, or depression. Mothers who were raising their child without a father showed greater warmth and interacted more with their child, but also reported more serious (though not more frequent) disputes. There were no differences in the mothers' overall adjustment, in mothers' emotional involvement with their children, or in their experience of stress related to parenting (Golombok et al., 1997).

Gender Identity and Sexual Orientation of the Children

Many questions have been raised about the gender identification and sexual orientation of children brought up in a family led by lesbians and/or gay men. While of theoretical interest, the exploration of this question also exposes a dubious assumption. Most of the research that has set out to investigate the adult sexual orientation of children brought up by a lesbian or a gay parent is based on the belief that an increased tendency toward a homosexual orientation among the children would be undesirable.

The diversity of available samples, and the generally young age of their children, makes a definitive determination of effect impossible. Most data concern children who have both a father and a mother, in most cases divorced. They should not be generalized arbitrarily to families formed by adoption or birth of a child by same-sex couples. Furthermore, the gender of the child in relation to her/his parents may be an important factor; therefore sons and daughters of gay men and of lesbians should be considered separately.

Both environmental and genetic mechanisms might result in an increased likelihood for children who have a lesbian or gay parent to develop a homosexual orientation. Among the postulated environmental influences on gender role and sexual orientation are imitation, socialization, and promotion of

tolerance (Bailey et al., 1995). Children imitate their parents in many ways, and in identifying with their same-sex parent they might come to prefer the same kind of intimate relationship that their parents model. This mechanism lacks consistency in that most homosexual adults have heterosexual parents. Nevertheless, imitation of parental role models may account for differences in what children imagine to be possible. Gay and lesbian parents might reinforce—or at least fail to discourage—behavior that is consistent with the development of a homosexual orientation in their children. It does seem logical to assume that by demonstrating their acceptance of non-heterosexuality, gay and lesbian parents broaden the range of sexual behaviors and orientation that their children might be comfortable to explore.

If there is a genetic contribution to the development of a homosexual orientation, children conceived by a gay man and/or a lesbian woman could be expected to have a greater likelihood of having a homosexual orientation themselves. Empirical data are needed to confirm or disprove this theoretical proposition.

Only a few studies include adults whose parents were gay or lesbian. Therefore, most available data concern aspects of the play, playmate, and activity preferences of pre-adolescent children. Early studies failed to identify any differences in the gender identification or gender-role preferences among children based on the sexual orientation of their parents (Golombok et al., 1983; Green, 1978; Hoeffer, 1981; Kweskin & Cook, 1982). More recently, pre-adolescent children of divorced lesbian mothers have been reported to dress, play, and behave in ways that do not conform to rigidly sex-typed norms more often than do their peers whose mothers are heterosexual. The children did not differ, however, in their gender identity or wish to be the opposite sex (Green et al., 1986). Daughters of lesbian mothers more often aspired to non-traditional occupations such as lawyer, engineer, doctor, and astronaut than did daughters of heterosexual mothers (Green et al., 1986; Steckel, 1987).

Children raised by lesbian mothers from birth also appear to have preferences for playmates, toys, and activities that are quite normative for their age (Weisner & Wilson-Mitchell, 1990). For example, every child in the Bay Area Family Study (age 4–9) reported that his or her group of friends was mainly or entirely made up of children of the same sex, as were the majority of their favorite movie and TV characters. None of the children studied to date has shown any evidence of gender-identity confusion or wishes to be the other sex (Patterson, 1994). Neither heterosexual nor homosexual mothers preferred that their children would become homosexual, but rather they uniformly wished for them to marry and have children (Javaid, 1993). A large investigation recently failed to show any effect of father absence on the development of gender role behavior in either boys or girls (Stevens, Golombok, & Beveridge, 2002).

A few studies have reported on the sexual orientation of *adults* who were raised by a lesbian and/or a gay parent. Among adult daughters of 35 divorced heterosexual mothers and adult daughters of 35 divorced lesbian mothers, no differences were found in gender identity, social roles, or sexual orientation (Gottman, 1989). The most extensive study of the adult sexual orientation of

the sons of gay fathers (Bailey et al., 1995) showed only modest effects based on the father's sexual orientation. Gay fathers and their sons identified only 9% as bisexual or homosexual—a prevalence that may be somewhat greater than that in the population as a whole. The length of time the sons had lived with their fathers did not affect the likelihood of their identifying themselves as gay.

Among 8 men and 17 women who had been raised as children in families with a lesbian mother, and a comparison group of 12 men and 9 women who had been raised by a single heterosexual mother (Tasker & Golombok, 1997), similar proportions reported feelings of attraction towards someone of the same gender. Both men and women whose mothers were lesbian were more likely to consider the possibility of having a same-sex partner, and six had been involved in at least a brief relationship with someone of the same gender, compared to none of the young adults whose mothers were heterosexual. Nevertheless, only two of the 17 women identified themselves as lesbian (Golombok et al., 1995). This body of research must be considered still tentative. The longest period of follow-up is still less than 30 years, and all samples are small.

Children's Emotional and Social Development

Children Born into a Heterosexual Relationship. Because most children whose parents are gay or lesbian have experienced the divorce of their biologic parents, their subsequent psychological development has to be understood in that context. Whether they are subsequently raised by one or two separated parents and/or whether a step-parent has joined either or both parent(s) are important factors for children, but rarely addressed in research assessing the outcomes for children of having a lesbian or gay parent.

The considerable research literature that has accumulated has revealed that children of divorced lesbian mothers grow up in ways that are very similar to those of children of divorced heterosexual mothers. Extensive, well-validated psychiatric interviews (Graham & Rutter, 1968) using interviewers 'blind' to the family background of the children have assessed children's psychological adjustment in several studies of children who were living with their mothers after divorce (Golombok et al., 1983; Huggins, 1989; Kirkpatrick et al., 1981). No differences were found between the children with lesbian and those with heterosexual mothers in the number or type of psychiatric difficulties. Children's teachers also failed to identify more or different emotional or behavioral problems in the children whose mothers were lesbian than in those whose mothers were heterosexual.

Several other studies comparing children with a lesbian mother to children with a heterosexual mother have similarly failed to document any differences after divorce on personality measures, measures of peer-group relationships, self-esteem, or the warmth and quality of family relationships (Brewaeys et al., 1997; Green et al., 1986; McNeill et al., 1998; Patterson, 1992, 1997; Tasker, 1995). Rates of behavioral and family difficulties appear to be present to the

TABLE 5.1. Studies Comparing Lesbian/Gay Parents to Heterosexual Parents

Author	Sample	Comparison Group	Findings
Pagelow 1980	20 lesbian mothers	23 single heterosexual mothers	Lesbian mothers less likely to have full custody of child(ren); to have permanent housing; more often fired; more likely self-employed
Miller, Jacobsen, & Bigner 1981	34 lesbian mothers	47 heterosexual mothers	Lesbians had greater "child orientation"
Scallen 1981	20 gay fathers	20 heterosexual fathers	No difference in relationship of fathers and children; no difference in problem-solving, recreation, autonomy; gay fathers report greater nurturance; gay fathers report less emphasis on economic role
Kweskin & Cook 1982	22 lesbian mothers	22 single heterosexual	No difference in children's gender-role preferences
Harris & Turner 1986	10 gay fathers 13 lesbian mothers	2 heterosexual fathers 14 heterosexual mothers	No difference in parents' relationships with children
Bigner & Jacobsen 1989a	33 gay fathers	33 heterosexual fathers	Differences only in some motivations for parenting
Bigner & Jacobsen 1992	24 gay fathers	29 heterosexual fathers	No differences in parenting style
McNeill, Rienzi, & Kposowa 1998	24 lesbian mothers	35 heterosexual fathers	Similar scores in self-reported stress, adjustment, competence, and quality of relationships with families

TABLE 5.2. Studies Comparing Children Whose Parents Are Gay vs. not

Author	Sample	Comparison Group	Age of Children	Findings
Hoeffer 1981	20 children of lesbian mothers	20 children of divorced heterosexual mothers	6–9	Children with lesbian mothers more androgynous.
Kirkpatrick et al. 1981	10 children of divorced lesbian mothers	10 children of divorced heterosexual mothers	5–12	No difference in prevalence of psychiatric disorders.
Golombok 1983	37 children of 27 divorced lesbian mothers	38 children of 27 divorced heterosexual mothers	5–17	No differences in psychiatric disorders, children's behavior, gender identity, sex-role behavior, peer relationships. Children of lesbian mothers had more contact with fathers.
Green et al. 1986	56 children of 50 divorced lesbian mothers	48 children of 40 divorced heterosexual mothers	3–11	No differences in parental stress; children's intelligence, sexual orientation, gender-role preference, interpersonal relationships, or adjustment. Lesbians more likely to have a partner after divorce.
Steckel 1987	11 children born to lesbian couples	11 children born to heterosexual couples	1–5	No difference in separation-individuation, independence. Children of lesbians rated less aggressive, more affectionate.
Gottman 1989	35 children of divorced lesbian mothers	70 children of divorced heterosexual mothers	Adults	No differences in gender identity, social adjustment, sexual orientation.
Huggins 1989	18 adolescents with a lesbian mother	18 adolescents with a heterosexual divorced mother	13–19	No difference in self-esteem.

Bigner & Jacobsen 1989b	33 children of gay fathers	33 children of heterosexual fathers	3–24	No differences in father's level of involvement, intimacy; gay fathers more concerned about limit-setting, guidance.
Javaid 1993	26 children of 13 lesbian mothers	15 children of divorced heterosexual mothers	6–18	No difference in attitudes toward marriage and procreation.
Golombok & Tasker 1994	25 young adults raised by lesbian mothers	21 young adults raised by single heterosexual mothers	17–35	No differences in psychiatric problems, family relationships, sexual orientation, children's adjustment (anxiety, depression), family wellbeing. Children of lesbians had more G/L friends; more likely to consider same-sex sexual relationship; recall more stigma regarding own sexuality.
Flaks et al. 1995	children of 15 lesbian couples (8 girls, 7 boys)	children of 15 heterosexual couples (8 girls, 7 boys)	3–9	No differences in cognitive functioning, behavioral adjustment, parents' relationship. Lesbians more knowledgeable about parenting skills.
Brewaeys et al. 1997 (European Study of Assisted Reproduction)	30 children with lesbian mothers (conceived using DI)	38 children with heterosexual parents (conceived using DI) 30 children with heterosexual parents (conceived usual way)	4–8	No difference in parent-child relationships, children's behavior. Girls in DI heterosexual families had more emotional problems. Lesbian coparents had more "developmental" orientation; shared child care more equally.

(Continued)

TABLE 5.2. Continued

Author	Sample	Comparison Group	Age of Children	Findings
Golombok, Tasker & Murray 1997 (British Longitudinal Study)	15 children with a single lesbian mother 15 children with lesbian couple mothers	42 children of single heterosexual mothers 41 children of heterosexual couples	3–9	No differences in parenting stress, maternal anxiety, maternal depression, children's emotional adjustment, children's peer relationships. Mother-child relationship better when father absent (no difference by SO). Children's self-esteem better when father present (no difference by SO).
Chan et al. 1998a (Contemporary Families Study)	34 children with lesbian couple mothers 21 children with a single lesbian mother	16 children of heterosexual couples 9 children of heterosexual single mothers	5–11	No differences in children's adjustment by SO, but better when parental relationship better. No differences in parental adjustment, stress, depression, self-esteem, relationship satisfaction.
Chan et al. 1998b	30 children with lesbian couple mothers	16 children of heterosexual couples	5–11	No differences in parental satisfaction with child care. Children's adjustment (parent report and teacher report) better when child care shared. Lesbian parents prefer equal distribution of child care responsibilities.

TABLE 5.3. Qualitative Investigations of Gay and Lesbian Parents and their Children

Author	Sample	Outcome of Interest
Green 1978	37 children 21 lesbian mothers 16 transsexual parents	Sexual orientation
Miller 1979	14 children with a gay father 40 gay fathers	Sexual orientation Father-child relationship
Turner et al. 1990	Children with a gay or lesbian parent	Early play preferences Sexual orientation
Osterweil 1991	30 lesbian couples and their children	Relationship satisfaction Children's behavior Children's self-concept
Koepke et al. 1994	47 lesbian couples	Relationship satisfaction
Bailey et al. 1994	82 adult sons with gay fathers	Sexual orientation
Hare 1994	51 children with lesbian mothers	Family relationships Parents' concerns
Patterson 1994 (Bay Area Families Study)	37 children with lesbian mother(s)	Contact with extended family Children's behavior Children's self-concept Children's sex-role preference Relationship satisfaction
Patterson 1995 (Bay Area Families study—subset)	26 lesbian couples	Division of labor Parental relationship Mothers' mental health
Gartrell et al. 1996, 1999, 2000 (National Lesbian Family Study)	154 lesbian mothers (84 families)	Parental relationship Social supports Coping strategies Division of labor Relationships with family-of-origin Children's experiences of homophobia
Mitchell 1996	32 lesbian couples	Division of labor
Sullivan 1996	34 lesbian couples	Division of labor
Barrett & Tasker 2001	101 gay fathers	Difficulty of parenting experience Child's responses to gay parent

same extent after divorce among children with lesbian and heterosexual mothers. Of some interest is the finding that children whose mothers are lesbian had more positive feelings about their fathers and more frequent contact with them than did the comparison sample of heterosexual parents after divorce (Golombok et al., 1983; Tasker & Golombok, 1997).

Two studies have addressed the effect of mothers' re-partnering experience on children's adjustment. Children's self-esteem is reported to be higher in adolescents whose mothers (of either orientation) were in a new partnered relationship and among daughters who knew of their mother's lesbianism at a younger

age (Huggins, 1989). In addition, daughters whose lesbian mothers were involved in a new relationship rated themselves as feeling more secure in the world and in relationships than did those whose mothers remained single (Gottman, 1989).

Some have postulated that children whose parent(s) is/are lesbian and/or gay would be teased and embarrassed about their parent's sexual orientation and/or their family constellation, and that the ostracism of their peers might restrict their ability to form and maintain friendships. Lesbian mothers have reported, however, that their children had as good peer relationships as did the children of heterosexual mothers. Few children had any difficulties involving restriction of social activities or personal distress (Golombok et al., 1983, 1997). Children appear to cope rather well with the challenge of understanding and describing their families to their peers and teachers (Golombok & Tasker, 1994). In any case, if ostracism, isolation, and teasing are problems for those children, neither the problem nor the solution can appropriately be located within these children or their families.

There is only one study with long-term followup (Tasker & Golombok, 1997) and no evidence was found among those families of adverse effects on children's psychological well-being. The young adults with a lesbian mother were no more likely to report anxiety or depression than their peers whose mothers were heterosexual, and scores on standardized inventories of psychological functioning in both groups were well within the normal range. Extensive interviews revealed that their memories of having been teased during childhood were little different from those experienced by children raised by single heterosexual mothers, and intrafamily relationships were rated as equally good. Relationships between adolescents and their lesbian mother's new partner were significantly more positive than those between adolescents whose mother was heterosexual and a new male partner (Tasker, 1995, 1999).

A meta-analysis recently considered 18 reports in which children of gay and non-gay divorced parents were compared with respect to their development, interactions, and socialization (Allen & Burrell, 1996). The analysis included 13 studies that had reported data collected from parents and teachers, and 12 that reported from the perspective of the children. The results demonstrate a strikingly homogeneous pattern: no differences were found among the children that could be ascribed to the sexual orientation of the parents, whether the data were obtained from the child, the parent, or the teacher. While the numbers are not large, the results indicate sufficient power to detect even medium-sized effects.

Children Born to or Adopted by Lesbian Couples. The small body of literature that has accumulated regarding children raised by lesbian couples from the beginning similarly has documented few difficulties in children's development. In early work, children's independence, ego functioning, and object relations were assessed using parent interviews, parent and teacher Q-sorts, and structured doll-play techniques. The results documented very similar development among all the children. Some provocative differences were reported as well. Children of heterosexual parents saw themselves as being somewhat more aggressive than did children of lesbians, and their parents and teachers reported

them more often to be bossy, negative, and domineering. Children of lesbian parents more often saw themselves as lovable and were seen by parents and teachers more often as affectionate, responsive, and protective of younger children. The small sample size makes the data best viewed as suggestive (McCandlish, 1987; Steckel, 1987). Since all parents studied were women, the possible effects of gender cannot be separated from those of sexual orientation.

More recently, 4- to 9-year-old children in the Bay Area Family Study were rated by their mothers and their teachers using the Child Behavior Checklist. Social competence and behavior were rated to be very similar to the instrument's normative sample. Children also reported their self-esteem, sociability and aggressiveness to be similar to the instrument's norms. Of considerable interest is that these children whose mothers were lesbian reported both greater *stress* and a greater sense of *well-being* than had been reported by the instrument's normative sample. They reported that they more often felt angry, scared, or upset, but *also* that they more often felt joyful, content, and comfortable with themselves. This puzzling finding has been interpreted to suggest either that young children whose mothers are lesbian actually experience more stress *or* that they are more aware of and able to report about their emotional states. Once again, these differences may be related to the fact that all the parenting in these families was being done by women, rather than suggesting that it reflects an effect of sexual orientation. Overall, the social and personal development of children born to or adopted by these lesbian mothers has proceeded in a manner quite consistent with that expected among children of heterosexual mothers (Patterson, 1994, 1996, 1997).

It appears that the psychosocial adjustment of children is influenced more strongly by family processes and interactions than by the number and sexual orientation of their parents. Indeed, the adjustment of children who have two mothers seems to be correlated directly with the satisfaction of their parents with their relationship and specifically with the division of labor they have worked out with regard to child care and household chores (Patterson, 1995c). Children whose parents reported greater relationship satisfaction, more egalitarian division of household and paid labor (Chan et al., 1998), and more regular contacts with grandparents and other relatives (Patterson et al., 1998), were rated to be better adjusted and to have fewer behavioral problems by both parents and teachers. In Gartrell's ongoing longitudinal study, most children have grandparents who accept their lesbian parents and are involved with their grandchildren (Gartrell et al., 2000).

Fathers have an important role in heterosexual families. The development of children in the absence of a father has been studied primarily among children whose parents are heterosexual—comparing those raised in the context of an intact nuclear family with those raised by a mother living alone. The effect of one vs. two active parents thus cannot be separated from the effect of a male parent's presence in the home. Boys and girls raised in lesbian mother families have been found repeatedly to be well-adjusted and to be neither more nor less likely to demonstrate any behavioral or emotional difficulties compared to children in families that include a father (Golombok et al., 1997; Tasker, 1999).

Most have been reported to relate well with peers, and only a small minority found themselves faced with troubling homophobia.

The strength of children's attachment to their mothers has sometimes been noted to be stronger in the absence of a father. In addition, the quality of interactions between both mothers and the child in lesbian families has been rated as better than that between the father and the child in heterosexual families, whether conception had occurred using donor insemination or in the usual way (Brewaeys et al., 1997; Golombok et al., 1996). On the other hand, children whose families did not include a father were less confident about their physical skills and their cognitive/academic abilities compared with children who had a father at home. It seems that fathers make a unique contribution especially to certain aspects of children's developing self-esteem (Golombok et al., 1997; Tasker, 1999).

Children's own perception of their parents was similar in all family types; the non-biological mother in lesbian families was regarded by the child to be as much a "parent" as the father in the heterosexual families. With regard to their emotional/behavioral development, boys and girls raised in lesbian mother families were well adjusted and their gender-role development did not differ from that of children raised in heterosexual families (Brewaeys et al., 1997; Golombok et al., 1996).

CRITIQUE OF AVAILABLE RESEARCH

Several authors have criticized and devalued the accumulated research about children whose parents are gay and/or lesbian, arguing that the quality of the available evidence is too poor to allow for any valid conclusions (Lerner & Nagai, 2001; Morgan, 2001). These authors point out that samples have tended to be small and non-representative, outcomes often have been measured using non-standardized instruments, and unacceptable biases have been evident.

These critiques of the scientific literature regarding children whose parent(s) are gay and/or lesbian fail to acknowledge the power of the astonishingly similar findings reported over several decades by diverse investigators studying different samples and using different techniques. In contrast, not a single scientific investigation has been published to date that provides primary data demonstrating any adverse effects on children of having a gay and/or lesbian parent(s). While acknowledging that there is much still to be learned, the evidence available supports professional optimism and support for these parents who are exploring new patterns of nurturing their children and of expanding the horizons of their families and their communities.

Fortunately, increasingly expansive, representative, longitudinal, and rigorous research is being conducted currently that will provide even stronger grounds for conclusions about the effects of different parent/family arrangements on children's development. As in every realm of child and family development, more and better research is in the best interests of children.

STIGMA AND DISCLOSURE

Children of lesbian and gay parents are involved in many diverse relationships with both heterosexual and homosexual members of their families and communities. The pervasive stigma associated with homosexuality affects children who have one or more parent(s) who is/are gay or lesbian in various ways. Most directly, children may be teased or ostracized by peers, and have difficulty making friends. Adults may also indicate their disapproval of the child's parents and family, compounding the social isolation and loneliness these children experience.

Children's recognition of stigma resulting from medical conditions has been found to affect their self esteem (Westbrook et al., 1992; Becker, 1981). Adolescents have reported a wide range of experience with stigma regarding their parent's homosexuality. Despite intense loyalty and protectiveness toward their mother and active valuing of diversity, teenage girls in one study reported a strong need for secrecy about their mother's lesbianism in order to make and maintain relationships. They also acknowledged concerns about being devalued by future romantic partners, and reluctance to include their mother's partner in social activities (O'Connell, 1993). Of interest however is one report that adolescents who disclosed their mother's lesbianism to their friends reported higher self-esteem and closer friendships than those who did not disclose (Gershon, 1999). Nevertheless a young man told me recently "I'm in hiding. I'm scared to tell people about my mom, because if they knew they might not like me. I feel like a secret alcoholic." An adult woman told me "I always felt that somehow I must be not-normal, that eventually I would figure out what was wrong with me... still now I feel like people won't accept me if they know that my father is gay". Another reported the relief she felt when her male date arrived wearing a "gay pride" lapel pin; now she knew that it would be safe to tell him that her father was gay.

The consistent effect of stigma on adolescents' self-esteem can potentially be modified by the adolescents' learned strategies for coping with it (Cramer, 1986; Gershon et al., 1999). Little has been written to help children with the process of "selective disclosure" (Deevey, 1989). Participation in social and advocacy groups such as COLAGE and Family Pride may provide support and advice. The growing fiction and non-fiction literature described in Chapter 7 may also provide some assistance.

The decision parents make and their process of "coming out" to their children has been studied very little. It seems that earlier disclosure (at least prior to adolescence) encourages children to accept their parent's homosexuality more readily. In general children's reactions after an initial period of shock are accepting, and they maintain close or even stronger relationships with both parents (Barrett & Tasker, 2001; Lynch, 2000; Deevey, 1989; Cramer, 1986).

Managing the anticipation and the experience of heterosexism or homophobia in the school environment is a frequent concern among lesbian and gay parents. In supportive communities, many of these parents have found opportunities to educate their children's teachers and classmates about the diversity

of family structures and in so doing to break down barriers of prejudice. In other communities, this sort of disclosure may present too great a risk. The resultant secrecy and deceptiveness about their family may be difficult for young children to understand and accept. Continuing efforts to confront and diminish heterosexist attitudes in schools and communities will surely result in greater security and acceptance. As one 7th grader stated recently, "kids deserve to be in an accepting, open community. One of the biggest things kids get teased about is being gay... students like to use the words fagot, homo, and other slang words... I have lesbian mothers and I feel disappointed and angry when I hear these words being used against other students." The increasingly visible activities of organizations like GLSEN and school-based "Gay-Straight Alliances" have begun to change the pervasive stigma and the climate of fear that are all too present in schools at all levels. Several resources are described in Chapter 7.

Little is known about what children conceived by alternative insemination techniques should be told about the circumstances of their conception, and when (Parks & Hamilton, 1991). Most lesbian couples who have conceived a child using alternative insemination techniques have told their children about their use of a sperm donor, whereas the majority of heterosexual couples who have conceived using donor insemination have not divulged this information to their child(ren) (Golombok et al., 1995, 1996; Mitchell, 1998). Children (especially adolescents) and adults often want to know their social history and genetic heritage. This information may have historical, ethnic, and medical implications in addition to its clear emotional grounding. If an unknown/unidentifiable sperm donor has been used, children may need help in coming to terms with their loss in never being able to know their biological roots. When the donor is known to the family, the considerations of whether and when to let the child know his role in her/his genetic makeup are even more complex. Keeping his true identity a secret may have unfortunate consequences in strained family interactions (Baran & Pannor, 1989); having it be known challenges the integrity of a family unit that does not include him. These considerations create a complex dilemma that families headed by a lesbian couple must confront as their children grow up (Barrett, 1997).

Some same-sex couples are experimenting with new roles for the person of the opposite sex who has contributed to the child's conception. Gay couples are finding ways to include a surrogate mother in the lives of their child(ren), somewhat analogous to the roles of birth mothers in open-adoption arrangements. Lesbian couples have included sperm donors and sometimes their partners (gay or not) in their families in a variety of ways. Some have the status of co-parents in nurturing and decision-making; more are accorded a role similar to an uncle; still others have a more distant relationship as supportive friends.

SUMMARY

Lesbian and gay parents appear to have parenting styles and quality of relationships with their children similar to those of heterosexual parents. Despite

occasional protestations (Cameron, 1999; Lerner & Nagai, 2001; Morgan, 2001), every study to date has shown that parental sexual orientation has no measurable effect on the quality of parent-child relationships or on children's mental health or social adjustment. Apparently parents' sexual orientation is irrelevant to their ability to provide a home environment that supports children's development.

Since children whose parents are not both heterosexual undoubtedly contend with a degree of social stigma even under the best circumstance, the similarity seen repeatedly in children's outcomes suggests the presence of some compensatory processes in these families. Exploration of how these families protect their children and help them cope with stigma could be helpful for all kinds of families.

On the other hand, it is premature to discount possible long-term effects associated with being raised in any of the variety of same-sex family arrangements. The small and non-representative samples studied, and the relatively young age of most of the children, give reason for restraint. Gay and lesbian parents may not, despite their best efforts, be able to protect their children fully from the effects of stigma and discrimination. Furthermore, it would not be surprising if some of the vast diversity of family forms being created by lesbian and gay parents would prove more conducive to healthy psychosexual and emotional development than others. Participation in different family structures is likely to affect children in various ways that may not be evident until they are adults. Heterosexual parents may benefit from learning of some experiences gay and lesbian parents have encountered as they raised their children, just as some characteristics of heterosexual couples might be helpful to lesbian and gay couples in their parenting efforts.

It is important to emphasize also that considerable diversity exists among the population of children whose parents are not heterosexual. The life of a child who lives alone with her divorced gay father is surely different from that of a child born to a well-functioning lesbian couple, and different as well from one who lives with his divorced lesbian mother and lesbian step-mother. The roles of the sperm donor or surrogate mother and the child's gender are likely also to affect family relationships and life experience.

Research exploring the diversity of parental relationships among gay and lesbian parents is just beginning. Some reports have already emerged and provide some guidance. Children whose parents divorce (whatever their sexual orientation) are better off when their parents have high self-esteem, maintain a responsible and amicable relationship, and are currently living with a partner (Cummings & Davies, 1994; Emery, 1982). Children living with divorced lesbian mothers do better when they learn of their mother's homosexuality at a younger age, when their fathers and other important adults accept their mother's lesbian identity, and perhaps also when they have contact with other children of lesbians and gay men. There is ample evidence that it is beneficial for both parents and children if the daunting tasks of parenting can be shared. Young children seem to benefit from arrangements in which lesbian parents divide child care and other household tasks in an egalitarian manner, as well as when conflict between partners is low.

Much more exploration is needed to clarify the economic, religious, cultural, and ethnic diversity of gay and lesbian parents, as well as their multiple different family forms, and how these factors affect their children. Studies also are needed to explore the nature of the stresses encountered by children of gay or lesbian parents and what protective factors in their extended families and in their communities can be mobilized to support them. In the meantime, though, a substantial body of research has failed to identify any significant developmental difficulties encountered by children whose parents are lesbian or gay. Indeed, some evidence gives us reason to wonder what special skills these children may be stimulated to develop in response to their experience with discrimination and heterosexism. Confident optimism and enthusiastic support are warranted in helping lesbian and gay parents to promote their children's development and well-being.

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6

Opportunities for Child Health Professionals

If I were a moose and you were a cow
Would you love me anyhow?
Would you introduce me to your folks;
Would you tell your friends, "no moose jokes!"
If I were a moose and you were a cow?

Fred Small, singer-songwriter

Pediatricians can work to improve the lives of gay and lesbian individuals of all ages as community and political leaders, as advocates for change in their office and hospital settings, in the context of the clinical care they provide, and as members of professional educational institutions. Tremendous potential has been created by recently-increased focus on gay and lesbian issues within pediatric health care.

Health care clinicians can be resources to all children and adolescents for advice and information regarding sexual behavior, its risks, and their sexual orientation. They may be a valuable source of support and advice for adolescents who are preparing to disclose their homosexuality to parents, peers, and teachers, and if the adolescent anticipates or encounters rejection after such disclosure. Information about their prospects for future intimate relationships and opportunities for parenthood may be beneficial to these teenagers and to their parents. Parents of gay and lesbian teenagers also will appreciate any information, support, and advice their child's physician can provide, as well as her/his support for the adolescent her/himself. Lesbian and gay couples considering parenthood may consult a child health professional for advice in making decisions regarding sperm donation, adoption, and surrogacy options. Lesbian and gay parents may have questions about how to help their children understand their parents' sexual orientation and their family's development and constellation, and may appreciate advice regarding coping with possible criticisms. Sensitivity, information, and access to appropriate care are

TABLE 6.1. Roles for Health Care Professionals on Behalf of Gay and Lesbian Youth and families

Community Advocacy
- Help to raise awareness and acceptance among school and community leaders of issues relevant to non-heterosexual individuals and families.
- Support the inclusion of materials about gay and lesbian issues in school curricula and in school and community libraries.
- Support the development and maintenance of school-based and community-based support groups for gay/lesbian students, their friends, their parents, and children whose parents are gay/lesbian.
- Initiate and support AIDS prevention/education efforts.
- Develop and/or request continuing education opportunities for health-care personnel related to issues of non-heterosexual youth and families.

Safe and Supportive Health-Care Environments
- Assure confidentiality.
- Implement policies against homophobic jokes and remarks.
- Be sure that informational forms use gender-neutral language and are free of heterosexist bias.
- Display posters, brochures, and information on bulletin boards that demonstrate support of issues important to gay and lesbian youth, parents, and their families.
- Provide information about support groups and other resources for non-heterosexual parents, teens, and their friends and families.

Comprehensive Health Care
- Be aware of the special issues surrounding the development of the range of mature sexual orientations.
- Assure confidentiality.
- Discuss emerging sexuality with all adolescents.
- Discuss family constellation and sharing of child care responsibilities with all parents.
- Use gender-neutral language in discussing sexuality.
- Give evidence of support and acceptance to adolescents questioning their sexual orientation.
- Provide information and resources regarding lesbian and gay issues to all interested adolescents.
- Provide information and resources to gay/lesbian parents and their children.
- Offer support for adolescents faced with or anticipating conflicts with families and/or friends.
- Provide "safer sex" guidelines to all adolescents.
- Provide further screening and education as indicated for each adolescent's sexual activity.
- Ensure that referral and consulting colleagues are respectful of the range of adolescents' sexual orientations.
- Encourage lesbian/gay parents to help their child(ren) recognize and resist stigmatization and criticism.
- Initiate opportunities for discussions of concerns about sexual orientation in regular health supervision encounters.

Medical Education
- Increase curricular attention to gay & lesbian issues.
- Speak about experiences of stigma and marginalization.
- Develop systems to support students, staff, faculty who are not heterosexual.
- Advocate for inclusion of homosexuality in affirmative action programs.
- Improve access to and visibility of appropriate health care options.
- Develop research programs that focus on issues of concern to non-heterosexual patients/families.

important for transgender individuals as well (Israel & Tarver, 1997; Lombardi, 2000).

COMMUNITY ADVOCACY

Advocacy efforts directed toward gay and lesbian teenagers and their parents, and those focused on gay and lesbian parents and their children, have much in common. Physicians can help to raise awareness and acceptance of these family groups among school and community leaders. Examples of such efforts include serving as a consultant or adviser to a community youth group or to a middle or high school's extracurricular activity group. National organizations and their local chapters that support gay and lesbian teenagers, parents, and their families generally welcome the participation of child health professionals in their activities. If a local community support group for any of these constituencies does not already exist, child health professionals can be helpful in mobilizing community resources to organize them. Of course, financial contributions are also always welcome. Many of these organizations also have annual meetings at which presentations by interested professionals are welcomed.

Many books are available to facilitate community education. Books for very young children generally describe the experience of having parents of the same sex and suggest strategies for introducing these families to curious peers. A growing collection of fiction may help middle school children and young adults to understand the diversity of sexual orientation and family constellations. Fictional characters provide a unique perspective that might otherwise not have been accessible to some teenagers. Several collections of essays and explicit guide books also provide a window into the shared experiences and feelings of others. These books are helpful for *all* teenagers in helping them to understand the concerns and life experiences of gay and lesbian adolescents and adults. Several books are intended for gay and lesbian adults interested in planning for parenthood and coping with the associated decisions and concerns. Physicians should encourage their local school and community libraries to have a wide variety of these books available. An annotated list of recommended books is provided in Chapter 7.

Pediatricians and other child health professionals may serve also as advisers to schools. Curricular materials should be available for every age level that present the diversity of family structures and address issues related to sexuality and sexual orientation. In the early grades, children should be encouraged to describe and discuss the diversity of the families represented in the classroom, supported by reading materials, videotaped accounts, and, if possible, presentations by community members. Children who live with only one parent or whose parents live separately, children whose parents have created their families through adoption, interracial and international families, children whose parents are gay and/or lesbian, and blended families all are present in many classrooms. Children can be helped to see that a variety of acceptable family arrangements all share the primary function of providing nurturing and care of their members.

For children in the middle grades, children's typical developmental tasks bring issues related to sexuality into the spotlight. Children whose parent(s) are gay and/or lesbian may be vulnerable to stigmatization and hostility from peers. Social ostracism during a period when "fitting in" is so important to children and adolescents may result in embarrassment, social isolation, and awkwardness in developing appropriate peer relationships. Traditionally homosexuality is severely stigmatized, and slang expressions for homosexuality abound in children's teasing, criticism, and derision of each other. Because physicians are respected professionals, explicit statements and evidence of their acceptance of a broad range of sexual orientation and behavior carries an important message to impressionable young adolescents. As with the younger age groups, classroom materials and programs should present information about people with various sexual orientations and family structures and help all children to understand the value of this diversity. Classroom presentations by physicians, or their participation in extracurricular activities, committees, or on school boards provide evidence of these values.

At the high school level, pediatricians can serve as advisers to "gay-straight alliances" and other extracurricular activities, and can be available to speak to selected assembly programs or make presentations as part of classroom curricula. In this role, they have the opportunity to teach about and encourage safe and responsible sexual behavior, including various forms of sexual expression, and to advocate for educational and support programs in schools.

For example, a Republican governor created a Commission on Gay and Lesbian Youth in Massachusetts in 1993, which was responsible for imagining and engineering a state-wide "Safe Schools" program. This program provides education about gay and lesbian issues in schools, ensures the safety of non-heterosexual students, and provides funding for gay and lesbian or gay-straight youth groups within the schools. An early indication of the success of this program is decreased alcohol use, decreased number of sexual partners, and decreased rates of pregnancy among gay and lesbian youth, as shown on Table 6.2.

Child health care professionals certainly should be at the forefront in initiating and supporting AIDS prevention education efforts in schools at all grade levels and through community programs. Parent-teacher associations in community schools often provide avenues for effective education and advocacy. Physicians and other child health care professionals who are gay or lesbian have a special opportunity to be role models if they feel sufficiently comfortable to allow themselves to be recognized broadly in the community.

Physicians and other child health care professionals can be effective also in national and local politics. Their support for laws and statutes that forbid discrimination based on sexual orientation, their outspoken opposition to discriminatory policies and habits, and their participation in political initiatives on behalf of gay and lesbian rights all are effective ways to demonstrate support of sexual minorities. These efforts can be supported also through "letters to the editor" or "op-eds" in local newspapers, appearances in radio/TV productions, vocal positions on legislation currently considered at the local, state, or national level, and/or through speaking engagements.

TABLE 6.2. Associations between Gay-Sensitive HIV Instruction and the Sexual Practices of Gay, Lesbian and Bisexual Adolescents: Massachusetts, 1995

			Level of Gay-Sensitive Instruction					
	Odds ratio	95% Confidence Interval	None/ minimal (n=72)	Low (n=35)	Moderate (n=19)	High (n=19)	P	Comparisons[a]
Lifetime sexual practices								
Had sexual intercourse, %	0.60	0.35, 1.04	94.9	87.2	81.9	79.4	.067	
Age at first intercourse, mean (SE), y[b]	—		13.5 (0.26)	14.0 (0.37)	14.1 (0.56)	13.7 (0.51)	.706	
No. of sexual partners, mean (SE)[b]	—		4.0 (0.30)	3.5 (0.41)	2.9 (0.68)	2.6 (0.61)	.142	
Used alcohol or drugs before last sex, %[b]	0.51	0.32, 0.85	50.5	49.7	23.0	13.0	.010	$c^{0.05}$, $e^{0.05}$
Used condom during last sex, %[b]	1.16	0.77, 1.75	53.6	38.0	64.9	60.5	.471	
Recent sexual practices (past 3 mo)								
Had recent sexual intercourse, %	0.61	0.41, 0.91	78.2	71.9	82.6	39.1	.014	$c^{0.01}$, $e^{0.05}$, $f^{0.05}$
No. of sexual partners, mean (SE)[c]	—		2.2 (0.31)	2.6 (0.41)	2.0 (0.68)	0.6 (0.57)	0.33	$c^{0.05}$, $e^{0.05}$
Ever been or gotten someone pregnant, %[b]	0.53	0.27, 1.01	38.6	26.4	12.1	8.8	.057	
HIV-related instruction								
Received instruction on preventing HIV/AIDS,%	1.31	0.91, 1.89	67.0	70.8	87.8	77	.144	
Received presentation from person with AIDS,%	1.15	0.84, 1.58	43.0	47.8	51.8	52.1	.377	
Taught how to use condom,%	1.25	0.91, 1.72	40.1	46.8	60.4	51.5	.169	
No. of instructional topics covered, mean (SE)[d]	—		1.5 (0.14)	1.7 (0.20)	1.9 (0.26)	1.8 (0.25)	.426	
Talked to parents about AIDS, %	1.22	0.88, 1.69	54.7	51.5	54.8	71.3	.244	

Note: Models controlled for kind of community, percentage low-income families (federal definition), and age, sex, and race of student; [a]Where a=none vs low; b=none vs moderate; c=none vs high; d=low vs moderate; e=low vs high; f=moderate vs high level of gay-sensitive instruction; [b]Only sexually active students; [c]Only students sexually active in past 3 mo; [d]Range = 0–3.

Reprinted from the *American Journal of Public Health*, Volume 91(6), June, 2001, p. 943.

Professional associations provide yet another context for effective advocacy. Heterosexism and homonegative attitudes persist in all professions, as documented in Chapter 2. All health care fields would benefit from increased teaching about, visibility, and acceptance of non-heterosexual students and colleagues, and from expanded continuing education opportunities related to homosexuality.

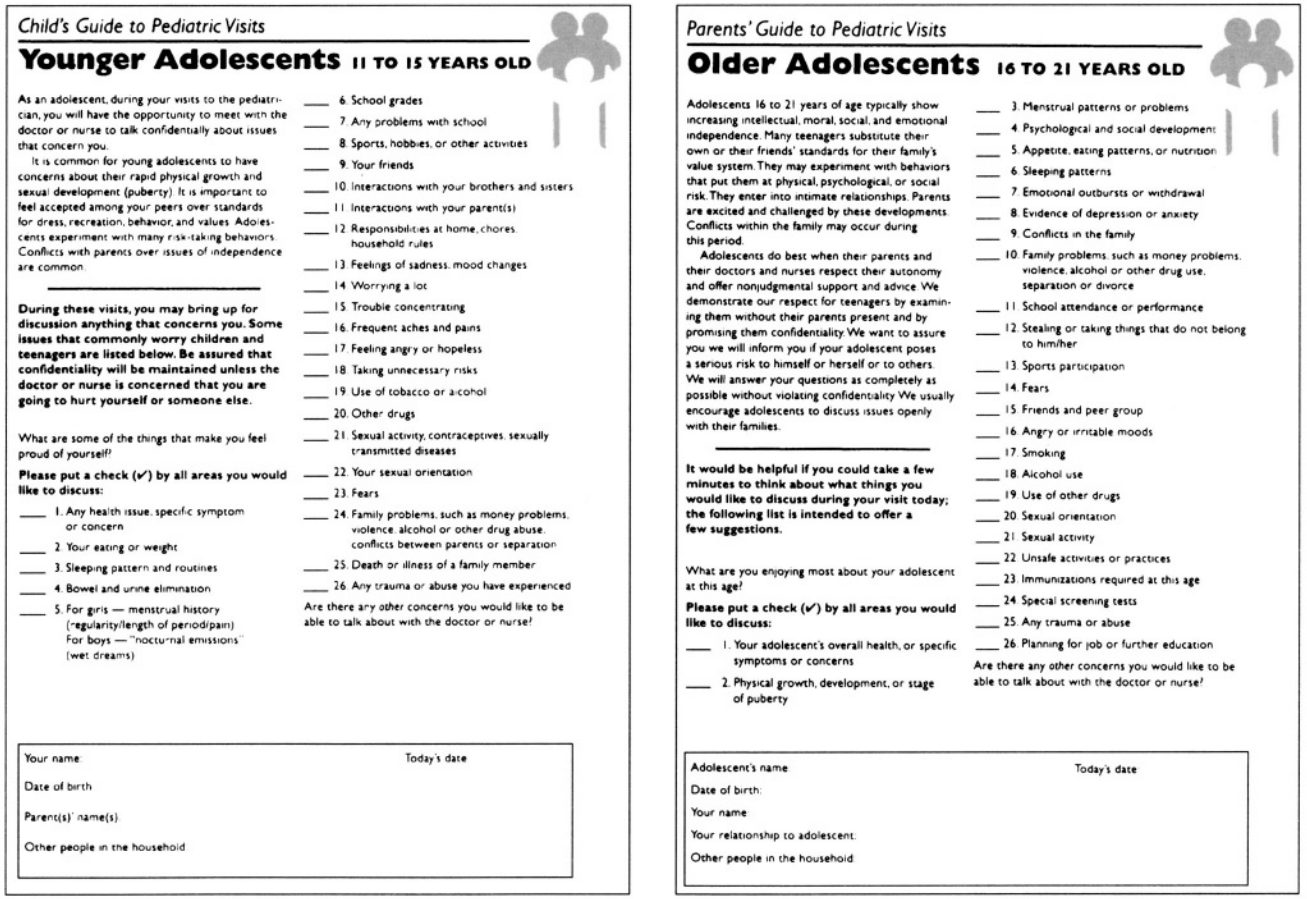
ATTENDING TO THE HEALTH CARE ENVIRONMENT

A safe and supportive setting is a prerequisite for all health care activities. Health care professionals must assure all patients and their families that they respect the need for confidentiality and honor the trust implied in their clinical encounters. People who have been subjected to discrimination and negative stereotyping may need special reassurance before they entrust their concerns and worries to health care professionals. Physicians should post prominently their policies about confidentiality and its limits; all staff members must be informed of the gravity of such policies, which must be scrupulously enforced. Strict policies against homophobic and other stigmatizing remarks, jokes, and slurs must be publicly announced and rigorously enforced in all health care contexts.

Recurrent experiences of stigma and discrimination make questions about or disclosure of homosexuality difficult and risky. One mechanism to make initiation of discussion about this and other potentially difficult topics more likely is to provide a way for adolescents to indicate their questions or concerns prior to the face-to-face interaction. Examples include a checklist format available from the American Academy of Pediatrics (AAP, 1997) (Figure 6.1). A less formal option is shown in Table 6.3 and can be modified to meet the needs and interests of individual practitioners. Once an adolescent has indicated a concern, it is the clinician's responsibility to initiate the relevant discussion.

Disclosure to a professional is privileged information and should be protected from careless dissemination. Some physicians make a policy of discussing with their patients whether and how such information will be recorded. For example, it may be appropriate to use an internal code to document sensitive information in the charts of adolescents or of children whose parent(s) is/are gay or lesbian so that this information will not become public without the patient's and parents' explicit consent. Such attention is important in anticipation that charts may be copied at a future time when patients change pediatricians, move on to an internal medicine practice, or require a consultation from a subspecialist.

Several mechanisms exist by which professionals and staff members can let patients and their families know indirectly of their acceptance of variations in sexual orientation. Posting relevant informational materials in waiting areas makes a powerful statement, as does the presence of books, magazines, and newspapers that describe and discuss issues of particular interest to gay and lesbian clients. The office bulletin board serves many functions, including providing information about community activities, groups, and other resources



Child's Guide to Pediatric Visits

Younger Adolescents 11 TO 15 YEARS OLD

As an adolescent, during your visits to the pediatrician, you will have the opportunity to meet with the doctor or nurse to talk confidentially about issues that concern you.

It is common for young adolescents to have concerns about their rapid physical growth and sexual development (puberty). It is important to feel accepted among your peers over standards for dress, recreation, behavior, and values. Adolescents experiment with many risk-taking behaviors. Conflicts with parents over issues of independence are common.

During these visits, you may bring up for discussion anything that concerns you. Some issues that commonly worry children and teenagers are listed below. Be assured that confidentiality will be maintained unless the doctor or nurse is concerned that you are going to hurt yourself or someone else.

What are some of the things that make you feel proud of yourself?

Please put a check (✓) by all areas you would like to discuss:

____ 1. Any health issue, specific symptom or concern
____ 2. Your eating or weight
____ 3. Sleeping pattern and routines
____ 4. Bowel and urine elimination
____ 5. For girls — menstrual history (regularity/length of period/pain) For boys — "nocturnal emissions" (wet dreams)
____ 6. School grades
____ 7. Any problems with school
____ 8. Sports, hobbies, or other activities
____ 9. Your friends
____ 10. Interactions with your brothers and sisters
____ 11. Interactions with your parent(s)
____ 12. Responsibilities at home, chores, household rules
____ 13. Feelings of sadness, mood changes
____ 14. Worrying a lot
____ 15. Trouble concentrating
____ 16. Frequent aches and pains
____ 17. Feeling angry or hopeless
____ 18. Taking unnecessary risks
____ 19. Use of tobacco or alcohol
____ 20. Other drugs
____ 21. Sexual activity, contraceptives, sexually transmitted diseases
____ 22. Your sexual orientation
____ 23. Fears
____ 24. Family problems, such as money problems, violence, alcohol or other drug abuse, conflicts between parents or separation
____ 25. Death or illness of a family member
____ 26. Any trauma or abuse you have experienced

Are there any other concerns you would like to be able to talk about with the doctor or nurse?

Your name: Today's date:

Date of birth:

Parent(s)' name(s):

Other people in the household:

Parents' Guide to Pediatric Visits

Older Adolescents 16 TO 21 YEARS OLD

Adolescents 16 to 21 years of age typically show increasing intellectual, moral, social, and emotional independence. Many teenagers substitute their own or their friends' standards for their family's value system. They may experiment with behaviors that put them at physical, psychological, or social risk. They enter into intimate relationships. Parents are excited and challenged by these developments. Conflicts within the family may occur during this period.

Adolescents do best when their parents and their doctors and nurses respect their autonomy and offer nonjudgmental support and advice. We demonstrate our respect for teenagers by examining them without their parents present and by promising them confidentiality. We want to assure you we will inform you if your adolescent poses a serious risk to himself or herself or to others. We will answer your questions as completely as possible without violating confidentiality. We usually encourage adolescents to discuss issues openly with their families.

It would be helpful if you could take a few minutes to think about what things you would like to discuss during your visit today; the following list is intended to offer a few suggestions.

What are you enjoying most about your adolescent at this age?

Please put a check (✓) by all areas you would like to discuss:

____ 1. Your adolescent's overall health, or specific symptoms or concerns
____ 2. Physical growth, development, or stage of puberty
____ 3. Menstrual patterns or problems
____ 4. Psychological and social development
____ 5. Appetite, eating patterns, or nutrition
____ 6. Sleeping patterns
____ 7. Emotional outbursts or withdrawal
____ 8. Evidence of depression or anxiety
____ 9. Conflicts in the family
____ 10. Family problems, such as money problems, violence, alcohol or other drug use, separation or divorce
____ 11. School attendance or performance
____ 12. Stealing or taking things that do not belong to him/her
____ 13. Sports participation
____ 14. Fears
____ 15. Friends and peer group
____ 16. Angry or irritable moods
____ 17. Smoking
____ 18. Alcohol use
____ 19. Use of other drugs
____ 20. Sexual orientation
____ 21. Sexual activity
____ 22. Unsafe activities or practices
____ 23. Immunizations required at this age
____ 24. Special screening tests
____ 25. Any trauma or abuse
____ 26. Planning for job or further education

Are there any other concerns you would like to be able to talk about with the doctor or nurse?

Adolescent's name: Today's date:

Date of birth:

Your name:

Your relationship to adolescent:

Other people in the household:

FIGURE 6.1. Sample of AAP checklists for parents and for children/adolescents to complete prior to office encounter. Available for all ages from the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60009. Reprinted with permission.

for parents and children who share various common interests. Information can be posted there about local support groups for lesbian and gay youth, meetings of the local chapter of PFLAG, and discussion/play groups for gay and lesbian parents and their children. In addition to providing helpful information, such postings convey implicit messages of acceptance and express the value of community support. Even the minimal symbol of a pink triangle or rainbow sticker posted in the waiting room or in exam rooms can serve as an indication of the pediatrician's and the office's acceptance of sexual minorities.

Pictures depicting same-sex relationships and posters that invite discussion of sexuality (among other topics) serve as further reassurance that the office welcomes such topics as part of the care provided. The "Safe Place" poster, for example, encourages teenagers to talk about various adolescent issues (see Figure 6.2), among them sexual orientation, sexual behavior, and intimate

FIGURE 6.2. Poster appropriate for waiting room, appropriate for all patients. Available from Indiana Youth Group, P.O.Box 20716, Indianapolis, IN 46620.

relationships. Other posters suggest helpful responses for non-gay students and family members when a friend or relative "comes out" to them; others present a visual depiction of a variety of family constellations (Figure 6.3). Pediatricians may choose to display such posters *in* their main waiting room, or perhaps in an examining room or waiting area that is dedicated to adolescents.

It is prudent to check for heterosexist assumptions found in many hospital, clinic, and office informational forms and reading materials, as well as in commercially available educational and health promotional brochures. Child health professionals can rewrite some of these materials using gender-neutral language or search for similar literature that does not assume heterosexuality. Even such simple forms as those used to document insurance status or to register into the practice may have an implicit heterosexist bias. Many, for example, provide spaces allocated for the name of a "spouse" or "husband/wife;" these could easily be changed to "partner." Similarly, spaces designated for "mother" and "father" could as well request "parent" and "parent." If patients are asked to complete a history form or a symptom checklist prior to their office visit, its language also must be gender-neutral. If information about marital status is requested, an option should be provided for partnered but unmarried adults, since committed intimate relationships between partners of the same sex cannot currently be legitimized through marriage.

Brochures about adolescent sexuality should present information about the broad range of sexual orientation rather than assuming heterosexuality. Brochures should be available specifically for gay and lesbian youth as well, such as that produced recently by the American Academy of Pediatrics (Figure 6.4). Similarly, information for parents should be inclusive of the wide variety of family constellations that will be represented in most practices, including parents who are gay or lesbian—whether single or members of a same-sex couple. The American Academy of Pediatrics is currently preparing a public information brochure specifically focused on gay and lesbian parents.

Health professionals also have an opportunity to monitor and influence the hospitals where they practice. All hospital staff, including physicians, nurses, and trainees, should be mindful that their clients represent a wide range of sexual orientation and of family constellations and deserve fully respectful care. As in the office setting, policies that assure confidentiality and that forbid stigmatizing jokes and slurs must be clearly posted and enforced by all staff. Interested professionals could offer to present information about gay and lesbian issues and experiences at staff meetings or educational conferences for hospital staff.

Many of the recommendations made above regarding office environments apply to hospitals as well. Heterosexist assumptions that may be implied in forms and written materials should be noted and corrected. Both general indications of acceptance of sexual minorities and specific information relevant to clients of diverse sexual orientation should be visible and available. Recording of patients' sexual orientation in charts and on hospital wards should be done with care and sensitivity.

Hospital policies must be flexible enough to allow gay partners to participate in one another's care. If a child has coparents of the same sex, both should

FIGURE 6.3. Two posters specific to gay and lesbian adolescents/parents. Available from Wingspan Ministry, St. Paul-Reformation Lutheran Church, 100 Oxford Street North, St. Paul, MN 55104-6540.

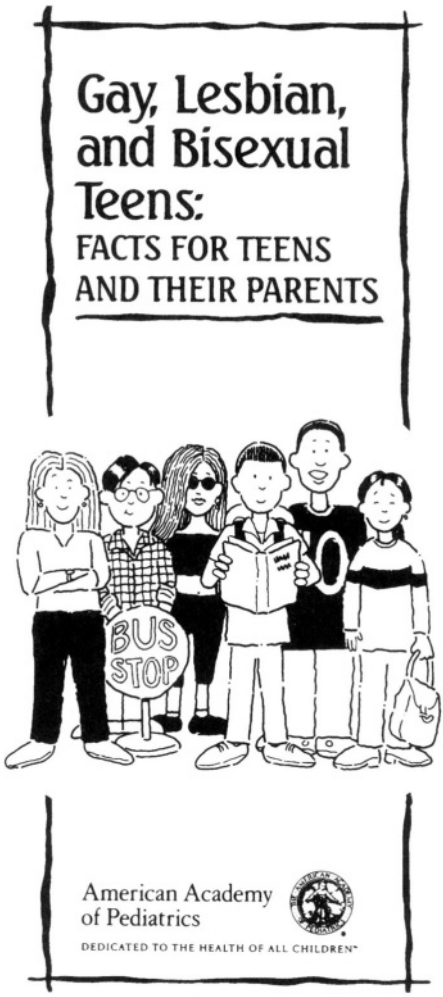


FIGURE 6.4. Brochure for general office display, available from the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60009.

be invited to be present with the child during procedures or overnight in the hospital; both should be kept informed, and they should be expected to fulfill all the responsibilities that are assumed of heterosexual parents. Domestic partner benefits should be made available to stable life partners of employees whether heterosexual or homosexual (O'Hanlan, 1999).

COMPASSIONATE AND COMPREHENSIVE HEALTH CARE

The realm of individual clinical care is likely to be the most familiar territory for most pediatricians and other child health practitioners. The clinical

encounter offers a special opportunity to be available as professional advisers to teenagers and adults who are struggling with questions about their sexual orientation, to those making difficult decisions regarding disclosing their homosexuality to parents or friends, and to others who are experiencing discrimination or other difficulties based on their sexual orientation. But the expanded responsibility is more extensive. Pediatricians and family physicians have an opportunity in the context of their care for young children and adolescents to redefine prevalent notions of sexuality. They can challenge commonly-held beliefs regarding what constitute "correct" gender roles from early childhood through adulthood. They can model acceptance of a variety of patterns of sexual attraction and sexual behavior. They can resist actively the idea that people who are different from prevalent norms are necessarily "deviant."

In the questions they ask they can encourage parents to ask and talk about the development of sexuality in their small children, as well as invite questions and discussion about a range of sexual behavior as children grow. If child health care contexts are safe for discussion about their own and their friends' emerging sexual fantasies, attractions, and behaviors, teenagers can come to understand and to accept a wide range of sexual orientation.

The goal for primary care physicians caring for children is not merely to identify those adolescents and those parents of their patients who are gay or lesbian or who are struggling to understand or to acknowledge their sexual orientation. Most adolescents will have some experience with and thoughts about homosexuality: they may have a parent, a sibling, an aunt or uncle, a peer, a teacher, or another contact who they know is or suspect may be gay; or they may have encountered homosexuality only through literature or the media. With increasing visibility of gay and lesbian leaders in political, academic, and social circles, adolescents' curiosity about the range of sexual orientation is likely to increase.

Health care professionals can model their appreciation of diversity in sexual orientation as in other characteristics. As a society, we have made great progress in breaking down assumptions—e.g., that doctors are men and nurses women, that people of color are poor and uneducated. Now we must take on the challenge to cease assuming that all of our colleagues, patients, and students are heterosexual.

Adolescent Health Supervision

Gay and lesbian youth have general medical needs and problems that are substantially similar to those of their heterosexual peers. Nevertheless some special attention to the process and content of health supervision efforts is warranted. The stigmatization and ensuing social isolation that they frequently encounter creates special vulnerabilities. Gay and lesbian adolescents may face additional health risks as a result of the nature of some of their sexual and social behavior, as well as considerable uncertainty regarding the level of support they can count on from their family, friends, and teachers. Pediatricians and other health care practitioners frequently are in a good position to assist them.

TABLE 6.3. Teenagers' Concerns

Teenagers usually have many things on their minds. In this office we hope to be able to help you cope with anything you are worried about. Remember, anything we talk about will be private and will not be disclosed to your parents, teachers, or anyone else without your permission (unless it involves your safety or someone else's safety). Please indicate which of the following topics you would like to discuss:

—— your skin
—— your weight or appetite
—— your parents
—— alcohol use
—— smoking
—— sexual activity
—— using drugs
—— birth control
—— sexual orientation
—— your friends
—— your school or teachers
—— your brothers or sisters
—— driving
—— aches or pains
—— violence
—— feeling sad or worried
—— anything else

All adolescents deserve correct information and open discussion about homosexuality. *The clinician's role is to facilitate all teenagers' healthy sexual development, not to determine or influence their sexual orientation.* Middle and high school students are aware of issues related to sexuality and worry about their own and others' sexual orientation and behavior. Many high school students state that they would like to discuss these concerns with a physician: 35% of 9th- and 12th-grade students in one survey reported that they wanted a physician to ask them "about your personal experience with homosexuality;" 38% of 9th-graders and 42% of 12th-graders wanted a doctor to give them explicit information about homosexuality (Rawitscher, 1996). Non-judgmental discussions of sexuality should be routine in the course of all adolescents' health care. Physicians should address sexuality as the complex interaction of sexual behavior, attractions, and fantasies that are intrinsic to adolescent development. They can create a context within which teenagers can discuss their sexual concerns and avoid or alleviate any associated shame or confusion. A pre-visit questionnaire (e.g. Table 6.3) may be a comfortable and efficient mechanism for adolescents to indicate that they would appreciate discussions about selected topics.

An especially urgent need is that *all* teenagers have a thorough understanding of HIV/ADDS and its prevention. All health care professionals are well aware of the increasingly urgent epidemic of HIV/AIDS and other sexually transmitted diseases among adolescents of *all* sexual orientations. "Safer sex" practices, including how to obtain and use condoms, should be discussed with and taught to all adolescents regardless of their current sexual behavior or identified sexual orientation. Counseling should emphasize education about transmission and prevention of HIV and stress the wisdom of limiting the number of sexual partners, avoiding the exchange of body fluids, and the regular use of condoms during all forms of sexual intercourse. Counseling and testing for HIV antibodies should be conducted whenever indicated with all sexually active adolescents, regardless of their gender or sexual orientation,

in a confidential manner and accompanied by education and counseling appropriate to the individual's needs.

Clinicians can facilitate helpful discussions about sexuality in a number of ways. Adolescents should be assured that monitoring of sexual development is an important and routine part of all adolescents' health supervision and reminded that the information they provide will remain confidential. It is critical that they articulate clearly their understanding that some adolescents may be unsure of their sexual orientation and that others know they are not heterosexual. Some lesbian or gay adolescents are reluctant to disclose their sexual attractions and behaviors and often hesitate to report worrisome physical signs and symptoms for fear that they might thereby reveal their sexual orientation. Their hesitancy may be due to personal denial, their fear of disapproval from physicians and other adults, or simply a lack of the information or the vocabulary necessary to discuss them. A non-judgmental, accepting manner and some initiative on the part of the clinician can help patients to discuss these issues. In some communities, adolescents who prefer can be referred to a health center or medical information service that is directed specifically at the concerns and health risks of gay and lesbian adolescents. In the absence of such a resource, there are many telephone "hotlines," websites, and e-mail groups that can provide information to adolescents about their particular health concerns, as well as an increasing number of resource books (see Chapter 7).

Critical to the success of such discussions is that clinicians take the initiative to discuss these issues at regular intervals throughout adolescence. It is not fair to expect a teenager who has been marginalized or experienced stigmatization and disapproval to do the hardest work of initiating a conversation about sexuality. Clinicians should make a clear statement of acceptance before asking any questions.

It is also very important that clinicians become comfortable with a manner of asking questions about sexuality that does not assume heterosexuality. Asking, "Are you involved in a relationship with a particular boy or girl?", provides a wider range of opportunities for response than "Do you have a girlfriend?" Other questions using gender-neutral language are provided in Table 6.4; each clinician will find his/her unique phraseology to invite adolescents to think about and to answer questions about sexuality. Whatever teenagers' responses may be to these questions, the act of asking them in itself makes an important and powerful statement. Asking about sexual activities, fantasies, and relationships using gender-neutral language implies both that many forms of sexual activity are acceptable and that this clinician is someone to whom it is safe to talk about their concerns regarding their own or other people's sexual behavior and sexual orientation. If an adolescent is offended by such questions, this response itself can become a useful opportunity for the clinician to introduce new information and to model a more inclusive attitude.

It is important to remember that sexual behaviors do not necessarily reflect sexual orientation. Considerable time, experience, and reflection may be necessary before individuals become certain of their true sexual orientation. Many

TABLE 6.4. Asking Gender-Neutral Questions

It is helpful to reassure *all* adolescents that questions about sexuality are a routine part of the health supervision visit. Questions such as these can be included in a written health history form or be part of an office interview. Adolescents should be assured that these questions are asked routinely and that responses are confidential.

Examples of appropriate questions include:

- Do you have a boyfriend or a girlfriend?
- Some of my patients your age date—some boys, some girls, some both. Are you interested in dating?
- Have you ever dated or gone out with someone?
- Have you ever been attracted to any boys or girls?
- Are you especially attracted to any boys or girls?
- There are many ways of being sexual with another person: petting, kissing, hugging, as well as having sexual intercourse. Have you had any kinds of sexual experiences with boys or girls or both?
- Are you currently involved in a steady relationship with a boy or a girl?
- How do you protect yourself and your partner against sexually transmitted diseases and pregnancy?
- Do you have any concerns about your sexual feelings or the sexual things you have been doing?
- Have you discussed these concerns with your parents or any other adults? Any of your friends?
- Do you consider yourself to be gay/lesbian, bisexual, or heterosexual (straight)?

teenagers explore both homosexual and heterosexual relationships and activities. Whatever their sexual orientation may turn out to be, they may be at risk for pregnancy and other risks of adolescent sexuality. Medical management generally should be guided by the adolescent's sexual *behaviors,* not his/her sexual *orientation.*

Homosexually-active young men should be tested for all classical sexually-transmitted diseases, such as syphilis and oral, anal, and urethral gonorrhea at intervals suggested by their sexual history. All sexually active young people should be immunized against hepatitis B, regardless of the sex of their partners. Lesbian adolescents, if neither they nor their sexual partners have been heterosexually active, are unlikely to develop sexually transmitted diseases. However, because many adolescents are actually sexually active with both men and women, discussions about sexually-transmitted diseases and contraceptive counseling may be appropriate. Each adolescent's particular risks that result from his/her pattern of sexual behavior will suggest indications for further screening and education.

The revelation of an adolescent's homosexuality may precipitate intense family discord. In some families, "coming out" may lead to physical and/or emotional abuse or even expulsion from the home. Adolescents' worries about their parents' possible responses must be taken seriously. Pediatricians may be in a good position to help adolescents get advice about how to disclose their homosexuality and to serve as a support during and after the process. He/she may be able also to assist parents in their early attempts to cope with—and

their eventual acceptance of—this information. Some parents may require professional help to deal with their confusion and possible feelings of anger, guilt, and loss.

Special considerations apply when a gay or lesbian teenager who has "come out" to a trusted health professional is referred for consultation by another clinician. Referrals and consultations should be obtained carefully from medical specialists and mental health practitioners who are known to be non-judgmental and accepting regarding homosexuality. Adolescents and their parents should be consulted regarding whether they want the clinician to pass along information about the teenager's sexual orientation.

Supporting Parents and Other Family Members

Much has been written about the experience of "coming out." Acknowledging their homosexuality and then disclosing it to their parents is indeed a daunting challenge, magnified if teenagers have reason to expect that their parents will find the information difficult to accept. Some parents consider homosexuality immoral and unacceptable and reject their children. Many are shocked and frightened at first but come to accept and help their teenager. Still others accept their child's homosexuality immediately, perhaps are not even surprised at the disclosure. Most parents do worry at least that their child's homosexuality will create a more difficult and more dangerous road through life than they had hoped for.

Even the most broad-minded parents may find the information that their son or daughter is gay or lesbian shocking, discomforting, and difficult. For most parents, the initial reactions include *fear* for their son's or daughter's health and wellbeing, *grief* at the loss of the adult child they had anticipated, and *guilt* about their own imagined role in the genesis of their child's sexual orientation. When one of their children discloses his/her homosexuality, most parents mourn the loss of an imagined and long-anticipated heterosexual life for their child, usually including a partner of the opposite sex and grandchildren. The recent possibilities and acceptance of parenthood for gay and lesbian couples may facilitate the adaptation of families to the news that their son is gay or their daughter a lesbian.

Typically, parents "go into the closet" when their children "come out." They may be reluctant to share the new information even with their other children, their parents, and their siblings. Comfort in speaking about their gay or lesbian teenager with coworkers, friends, and neighbors often takes considerable time and support (Borhek, 1988). Reassurance regarding the evidence that their parenting had little to do with their child's homosexuality is an important contribution that pediatricians can make to the parents' and the family's well-being at this stressful time of their lives.

It is important for teenagers to recognize that their siblings and parents may require some time to adapt to their news. The teenager has taken months or years to come to the recognition that he is gay or she is lesbian and to adjust to this reality. There is no reason to expect that his/her parents will immediately

understand and accept the new information. They too will need time, information, and support to come to terms with a new reality which is very different from the future they had imagined for their child. Grandparents and other relatives also may benefit from information, support, and advice from their adolescent child's pediatrician or other child health professional. Referral to and encouragement of the family's involvement in a local chapter of the national group, Parents and Friends of Lesbians and Gays (PFLAG), will provide support and access to extensive informational materials. Several books may be helpful as well to family members (see Chapter 7).

Children With One or Two Gay or Lesbian Parent(s)

Health care for children whose parents are gay or lesbian differs little from health care that is appropriate for all children. Just as for all children, both parents should be invited to prepare for and to participate in health supervision visits. Discussions about family and peer relationships are always an important part of health supervision. Parents and children should be invited to discuss their family's structure and functioning, including any concerns they may have about it. Parents may need some encouragement and/or advice regarding how to help their child(ren) recognize, discuss, and cope with stigmatization or embarrassment that arise as a result of their parent(s)' sexual orientation or their family constellation.

For many parents, the impact of social stigma is of paramount importance, especially as their child ventures out into school life. Professionals need to help parents to exercise some caution with regard to passing on their worry to their children, who may have an easier time introducing themselves and their families than their parents fear. Adolescents may find their parents' sexual orientation of more concern, and discussion with a professional may be helpful in order to make the home environment comfortable for teenagers and their friends. Parents could be encouraged to build social relationships with other families in which the parents are gay or lesbian; it is helpful for children of all ages to know others in similar circumstances. Information about helpful reading materials as well as about national and local groups of families in which one or both parents is/are gay or lesbian may be helpful.

Professionals may be able to help parents to identify strategies to help their children to manage painful encounters with homophobia. It is often helpful for children to be prepared for such experiences in advance, and to know how to respond to some predictable questions from curious peers. These strategies may change as children grow up and should be reassessed and discussed repeatedly.

One mother, for example, told her six-year-old son that he was free to tell his teacher and his friends that his mother was a lesbian, but she cautioned him that some children or adults might respond in a way that would hurt his feelings. She told him that if that happened it was not his fault or responsibility. She assured him that he was a good boy in a loving family. Such strategies allow children to control the information they disclose and prepare them for possible negative consequences of disclosure.

Older children may not reveal their feelings of marginalization or embarrassment about their homosexual parent(s), in part out of a concern that knowledge of their stigmatization might be hurtful to the parent(s). For example, one daughter said, "We all just pretended that we were a normal, happy family. But I lived in fear that my friends would find out that my dad was gay and that therefore there is something wrong with me."

In order to prepare children, parents have to first make difficult and complex decisions about disclosure. How freely are they willing to allow their child to describe their family? Are there risks to the child or the parents? Can they give children guidelines about "selective secrecy" and help them to understand how to make good decisions about disclosure? If the community can be educated adequately, full disclosure to schools and other organizations and individuals important in children's lives is most likely to be easiest for children. Parents of older children and adolescents can be helpful by describing some of their own encounters with homophobia and the strategies they have used to counteract it.

In the course of health supervision parents may ask for assistance in initiating discussions about the child's original family or about her/his conception. Health care professionals can suggest children's books and other materials that will help them to explain the process of their becoming a family (see Chapter 7). If children are preoccupied or worried about the absent parent or donor, or if the relationship between divorced parents is strained, a short series of meetings with a family therapist may be helpful in ensuring open communication among family members and support for the child(ren).

MEDICAL EDUCATION

Homosexuality has largely been ignored in the context of medical education. The concerns faced by gay and lesbian patients, students, physicians, and nurses have been rendered invisible by the fear that disclosure would jeopardize respect, medical care, or job status and security. Gay and non-gay physicians associated with medical centers can be effective advocates and agents of change towards diminishing the pervasive stigma that surrounds homosexuality. Such change will not be easy nor come quickly, as it challenges the pervasive heterosexism and homonegativity of the society. But because physicians are respected opinion leaders, their efforts can be powerful and create ripples that extend more widely than the confines of particular programs. While not the focus here, similar problems have been documented and solutions proposed in schools of nursing, physical and occupational therapy, and social work.

Physicians have a particularly important role in challenging the heterosexist atmosphere of medical schools, as documented in Chapter 2. Few medical schools currently have in place an appropriate system of support/advising for gay and lesbian medical students, nurses, faculty, or staff (Townsend, 1998; Townsend, Wallick, & Cambre, 1991, 1996). Gay and lesbian faculty members rarely feel sufficiently safe to make themselves available as advisers and role

models for gay and lesbian students (Brogan, Frank, Elon, Sivanesan, & O'Hanlan, 1999; Schatz & O'Hanlan, 1994). The content of medical school and residency curricula is scanty with regard to issues that focus on gay and lesbian concerns (Tesar & Rovi, 1998; Townsend, Wallick, & Cambre, 1995; Townsend, Wallick, Pleak, & Cambre, 1997; Wallick, Cambre, & Townsend, 1992). Physicians have the opportunity to work at changing that environment by fostering appropriate dialogue at all levels of medical education. They can help to develop systems of support for gay and lesbian students and faculty, as well as expanding the curricula for medical students and residents related to sexuality and sexual orientation (Cabaj & Stein, 1996; Lock, 1998).

At least five objectives need implementation in most medical schools:

(1) *Education*: increased and broadened teaching regarding gay and lesbian issues, including the effects of stigmatization, to medical students and residents in all departments;
(2) *Support*: development of a system of explicit support within the medical center for non-heterosexual students, nurses, residents, and faculty members;
(3) *Visibility*: institution of a "Gay and Lesbian Issues Subcommittee" as part of the Medical Center's Affirmative Action Committee;
(4) *Clinical programs*: improved access and welcome to non-heterosexual patients and their families through clinical programs explicitly designed to address their needs;
(5) *Research*: development of investigative programs that address issues of particular concern to non-heterosexual youth and families.

(1) Education. It is important that all health professionals be given an opportunity to learn about the complex histories and lives of gay and lesbian individuals. Makadon has suggested that to do this a curriculum must address:

- the experience of growing up feeling "different" and the implications of that experience in adult life;
- sexual behaviors and satisfaction;
- prior traumas and their current effects;
- health issues of particular concern to gay and lesbian individuals, including HIV/AIDS;
- individual variations and individual needs among all subgroups, including gay and lesbian communities (Makadon, 1998).

Teaching about sexual diversity should begin during the preclinical years of medical school and be augmented in the clinical years and during residency training. This work will require ongoing faculty development and professional support. It is important that sexual orientation be understood as one of many characteristics on which humans vary—neither in itself problematic nor the focus of explicit clinical attention. At the same time, the stigma which surrounds all but heterosexual orientations does create special difficulties and needs for some individuals and their families and must be discussed and addressed.

Medical education focusing on homosexuality and the concerns and needs of gay and lesbian individuals should not be centered around the epidemiology, prevention, and treatment of AIDS. While the devastating effects of this epidemic have taken a huge toll in the gay and lesbian community, it is only one of many health risks faced by gay and lesbian individuals. The generic stigmatization that surrounds homosexuality is compounded by the fear and blame that surround this particular condition. Furthermore, AIDS currently affects people of all races, ethnic backgrounds, genders, and sexual orientations.

Aspects of the development and variations in expression of human sexuality and clinical issues of particular relevance to gay and lesbian individuals should be integrated into the course content of all clinical rotations for medical students and into all residency training programs. Such integration is important in order to emphasize both the commonalities and the differences in the life experiences of gay and non-gay men and women.

Examples of material appropriate for lectures or seminar presentations for medical students and residents might include:

- definitions and epidemiology of diverse sexual orientations;
- typical developmental progression of sexual identity formation;
- discussing sexuality in primary care encounters:
  - exploration of students' attitudes towards sexual issues;
  - gender-neutral language;
- creation of families by gay and lesbian individuals;
- issues important to children whose parents are gay or lesbian;
- biomedical concerns of gay and lesbian adolescents;
- community support groups for gay and lesbian youth and adults;
- obstetric and gynecologic needs of lesbian women;
- assuring safety for gay and lesbian adolescents, including in schools;
- issues in mental health care for gay men and lesbians;
- helping parents and other family members accept their gay members.

Interventions in selected medical schools already have yielded important changes in attitudes. Increased knowledge and more tolerant attitudes about gay men and lesbians have been documented as a result of even brief interpersonal contacts (Lance, 1987; Millham, San Miguel, & Kellog, 1976). Presentations by lesbian and gay adolescents and their parents, by lesbian and gay physicians, and by gay and lesbian parents and their children are particularly suited to child health care contexts. Addition of a two-hour lecture/discussion about gay and lesbian youth to a pediatric clerkship resulted in a documented decrease in homophobic attitudes and in increased confidence about appropriate care for adolescents questioning their sexual orientation (Sack, Perrin, & Drabant, 2001).

Projects in which a homosexual and a heterosexual student worked cooperatively also reduced homophobic attitudes (Grack & Richan, 1996). Even videotaped accounts of personal and professional experiences of gay and lesbian adolescents and adults have been shown to increase both empathy and

knowledge (Gallop, Taerk, Lancee, & Coates, 1992; Walters, 1994). Panel and small-group discussions have helped medical students to understand gay and lesbian experiences and concerns (Wallick, Cambre, & Townsend, 1993, 1995). Each resident in a primary care specialty should have the opportunity to work directly in a clinical relationship with at least one family in which either a parent or an adolescent is gay or lesbian (Kelly & Langsang, 1999).

(2) Support. In order for fundamental change to occur, institutional administrations must first create an environment that is accepting and empowering of the homosexual members of its faculty and student bodies. Gay and lesbian faculty and students who have had the support and the courage to "come out" themselves can be a powerful force in affecting changes in attitudes within medical institutions (Goldfarb, 1997; Nguyen, 1999). Their own visibility can change the environment of their schools through personal relationships, support for other gay and lesbian students and faculty, and community advocacy. Explicit support should be provided at the leadership level by designating an administrative position for advocacy and support related to gay and lesbian issues at each medical center (Townsend, 1998; Wallick, 1997).

(3) Visibility. Formal programs of affirmative action have focused typically on minorities under-represented as a function of their race, ethnicity, or gender. Increasingly, equal opportunity offices and affirmative action committees have included people with disabilities in their purview, developing monitoring systems and programs to support affected students and faculty members. The particular concerns of non-heterosexual members of medical center communities traditionally have been less visible, consistent with the general ambivalence surrounding homosexuality (Wallick, Townsend, & Cambre, 1995). The particular contributions of the gay and lesbian medical community are important to all endeavors of teaching, patient care, and research. Diversity in sexual orientation must therefore become an explicit focus of equal opportunity efforts and part of the agenda of affirmative action committees.

(4) Clinical Programs. The medical establishment is often perceived to be judgmental and inaccessible by persons of stigmatized minorities. Health care communities themselves must take active steps to reassure their constituents of their genuine interest in and ability to meet their health care needs and to assist in their advocacy efforts. Some institutions have organized specific clinical programs for children whose parents are gay or lesbian and/or for gay and lesbian adolescents. Such programs appear to meet the desires of a segment of the gay and lesbian population. Others prefer full integration into ongoing systems of care, with assurance that these care systems and providers are sensitive to their particular needs and that they seek to avoid heterosexist bias in their provision of healh care (Perrin & Kulkin, 1996). In whatever way clinical services are organized, it is important that they include explicit connections with community support programs for gay and lesbian youth and for parents who are gay or lesbian. Careful attention to confidentiality and the possibilities of inadvertent disclosure of private information have become evermore critical as we communicate increasingly via computerized medical records and electronic mail. Generic attention to confidentiality, and assurance that it is taken

very seriously, are critical requirements for any attempts at improving access of health care services to gay and lesbian individuals and other stigmatized groups.

Gaps in clinical care of the non-heterosexual population have been documented. For example, despite the availability of an effective vaccine for nearly two decades, few adolescent and young adult gay men are vaccinated against Hepatitis B (MacKellar, D.A., Valleroy, L.A., Secura, G.M., McFarland, W., Shehan, D., Ford, W., LaLota, M., Celentano, D.D., Koblin, B.A., Torian, L.V., Thiede, H., & Janssen, R.S., 2001). In addition, gay men account for an increasing proportion of cases of gonococcal urethritis (Fox, K.K., del Rio, C., Holmes, K.K., Hook, E.W.III, Judson, F.N., Knapp, J.S., Procop, G.W., Wang, S.A., Whittington, W.L.H., & Levine, W.C., 2001). Given recent evidence that gonorrhea may facilitate transmission of HIV, this trend is of particular concern for adolescents.

Among young lesbian women, the prevalence of several health risk factors is increasing as well. They are more likely to smoke cigarettes and to drink heavily (Gruskin, E.P., Hart, S., Gordon, N., & Ackerson, L., 2001), as well as to be overweight (Aaron, D.J., Markovic, N., Danielson, M.E., Honnold, J.A., Janosky, J.E., and Schmidt, N.J., 2001). Preventive services must be made more accessible to adolescents and must address risk factors associated with non-heterosexual orientations in order to facilitate improved care and health status.

(5) Research Activities. Research is needed into many aspects of the health and health care of gay men and lesbians. Differential routes of transmission and rates of prevalence exist for various infectious diseases. The public health implications of genital herpes, gonorrhea, hepatitis and HIV are well known, but their treatment remains a challenge (American Medical Association, 1996). Cancer also may have different patterns of epidemiology among homosexual populations than are seen in the majority culture. Anal carcinoma, for example, is an increasing risk among gay men, and some are advocating regular anal pap smears. Less is known about these patterns than is needed for appropriate preventive care and screening guidelines (White & Levinson, 1995). Some studies suggest an increased risk of breast, endometrial, and ovarian cancer among lesbians, presumably because of the greater likelihood that they are nulliparous and are less likely to have breast fed (Dibble, Roberts, Davids, Paul, & Scanlon, 1999; Rankow & Tessaro, 1998; Roberts, Dibble, Scanlon, Paul, & Davids, 1998). Lesbians older than 40 report more tobacco and alcohol use than their heterosexual peers, but rates of lung cancer and cardiovascular sequelae are unknown.

Research is also needed to understand better the mental health needs of lesbians and gay men (American Medical Association, 1996; Rothblum, 1994). Health services research should explore the appropriate delivery systems that would maximize the likelihood of gay and lesbian clients making full use of both physical and mental health resources (Solarz, 1999). The changing face of heterosexism should be described systematically as well. An example of one way to assess attitudes is shown in Table 6.5.

Despite a growing body of scientific literature regarding donor insemination and surrogate mothering, many questions are left still unanswered regarding the health of children in planned gay and lesbian families. Are there risks

TABLE 6.5. Attitude Scale

1 = Strongly Disagree; 2 = Disagree; 3 = Agree; 4 = Strongly Agree	**1**	**2**	**3**	**4**
1. Gay men should not work with children.				
2. I would feel nervous about being with a group of lesbian women.				
3. It would be harmful to our society to allow gay men and lesbians to be legally married.				
4. If my son told me he was gay, I would wonder what I did wrong as a parent.				
5. I would be nervous if I found out my neighbor was gay.				
6. It is harmful for a boy to grow up in a family of two mothers.				
7. I would be angry if I found out my doctor was gay.				
8. I would feel comfortable working closely with a lesbian woman.				
9. The high suicide rate among gay teens reflects an underlying mental health disorder.				
10. I would feel nervous if were with a group of gay men.				
11. I would enjoy more opportunities to "hang around" with lesbian women.				
12. I would oppose a gay couple who wants to adopt a 4-year-old girl.				
13. I would enjoy being at a social event that several gay men and lesbian women were attending.				
14. If one of my friends told me she thought she was a lesbian, I would try to talk her out of it.				
15. Regulations to ensure diversity in medical schools and residencies should include sexual orientation, in addition to gender, race, and ethnic origin.				
16. I would feel comfortable working closely with a gay man.				
17. If I knew of a lesbian teacher in my son's school, I would try and arrange for him to be in her class.				
18. I would like my parents to know my friends who are gay.				
19. People who support gay rights campaigns are probably latent homosexuals themselves.				
20. I would worry if I knew my son's teacher was a gay man.				
21. Most people do not want to have a gay man as their doctor.				
22. If I were a doctor, I would let patients know they have a choice before referring them to a surgeon I knew was gay.				
23. I do not like the way gay men and lesbian women stick together and work to get extra benefits.				
24. I would like to have friends of my sex who are homosexual.				
25. I prefer to go to social events that do not include homosexuals.				

of subacute viral infection? How should sperm banks be monitored to prevent genetic overlaps? How, and how much, should children be told about the process of their conception? How can their parents best help them to feel secure in their family and their community and accepting of their particular family constellation? What special resources do children develop as a result of their non-traditional family structures? Indeed, how can these children and their families contribute to the diminution of heterosexism and homonegativity in their extended families, their communities, and their schools?

SUMMARY

Physicians, nurses, and other health care professionals can exert a powerful influence in support of gay and lesbian parents and their children, and of both gay and non-gay adolescents and parents of teenagers in their community. We can do this by avoiding and challenging assumptions of heterosexuality in the process of clinical care for children of all ages; by helping children and their families to understand the wide range of normal variation in sexual orientation; by helping schools and community organizations in their efforts to provide information and support to all children and families whatever their particular constellation. Within our own professional organizations we can work against homonegative attitudes that reinforce discrimination and the personal and professional limitations caused by stigma.

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7

Additional Resources

I. ORGANIZATIONS

Adolescents and their Parents:

The National Coalition for Gay, Lesbian, Bisexual & Transgender Youth
369 Third Street, Suite B-362
San Rafael, CA 94901-3581
e-mail: INFO@OUTPROUD.ORG
WEB: www.outproud.org
Provides resources and referrals for GLBT and questioning youth

PFLAG (National Federation of Parents and Friends of Lesbian and Gays)
1726 M Street, Suite 400
Washington, DC, NW, 20036
202.467.8180; FAX 202.467,8194
e-mail: pflagntl@aol.com
WEB: www.Pflag.org
A national organization devoted to support, education and advocacy regarding all issues of concern to gay men and lesbians and their families. Helpful publications. Check website for local chapters all over the world. Website and many publications in Spanish as well as English.

Lambda Youth Network
PO Box 7911
Culver City, CA 90233
310.216.1312
e-mail: lambdya@aol.com
Referrals to pen pal programs, newsletter, websites, hotlines and other resources for youth ages 12-23

National Gay and Lesbian Task Force
1734 14th Street NW
Washington, DC 20009-4309
202.332.6483

American Friends Service Committee, Bridges Project
1501 Cherry Street
Philadelphia, PA 19102-1429
215.241.7133
e-mail: bridgespro@aol.com

True Colors
Sexual Minority Youth and Family Services
WEB: www.ourtruecolors.org
A Hartford-based group with an wide network of contacts and information; extensive website

Horizons Community Services
Youth Services & Anti-Violence Program
961 West Montana Street
Chicago, IL 60614-2408
CONTACT: Jerri Lynn Fields
773.472.6469; TDD 773.372.1277
Anti-Violence 24-Hour Crisis Line: 773.871.2273

National Youth Advocacy Coalition
1711 Connecticut Avenue, NW, Suite 206
Washington, DC 20009
202.319.7596; FAX 202.319.7365
e-mail: NyouthAC@aol.com
Referral information for youth-serving agencies, services and support groups.

Particular focus on school issues:

GLSEN: Gay, Lesbian and Straight Education Network
121 West 27th Street, Suite 804
New York, NY 10001
WEB: www.glsen.org
Advocacy and information resources for all school-related issues. Extensive and helpful website including "bookstore". Excellent newsletter.

Project 10
c/o Virginia Uribe, PhD
Fairfax High School
785D Melrose Avenue
Los Angles, CA 90046
213.651.5200
The first school support program, now the model for all others. Counseling and education services. Video and handbook available.

PROJECT 10 East
Cambridge Public Schools
459 Broadway
Cambridge, MA 02138
617.349.6486; FAX 617.349.6897
Provides consultation on GLBT support services and safe schools, pre-K through high school

Hetrick-Martin Institute for the Protection of Lesbian and Gay Youth
2 Astor Place
New York, NY 10003-6998
212.674.2400

Human Sexuality Program
Toronto Board of Education
Student Support Services
155 College Street
Toronto, Ontario
Canada M5T 1P6
416.397.3755; FAX 416.397.3758
Comprehensive services for students, teachers, and families

The Harvey Milk School
2 Astor Place
New York, NY 10003-6998
212.674.2400; FAX 212.674.8650
An alternative high school for GLBT students

Teaching Tolerance
400 Washington Avenue
Montgomery, AL 36104
334.264.0286; FAX 334.264.3121
Curriculum materials, ideas, and strategies for teaching about diversity.

EAGLES Center
7051 Santa Monica Blvd.
Hollywood, CA 90038
213.957.0348
A Los Angeles program for GLBT teens

Massachusetts Governor's Commission on Gay and Lesbian Youth
State House, Room 111
Boston, MA 02133
617.727.3600, ext. 312
Information about the Safe Schools Program, support and development services

Gay and Lesbian Parents and their Children:

Children of Lesbian and Gays Everywhere (COLAGE)
3543 18th St. #1
San Francisco, CA 94110
415.861.5437
e-mail: COLAGE@CQLAGE.org
WEB: www.COLAGE.org
Many local chapters with family activities and support

Family Pride Coalition (formerly Gay and Lesbian Parents Coalition)
PO Box 65327
Wahington DC 20035-5327
202-331-5015
e-mail: pride@familypride.org
WEB: www.familypride.org
Many local chapters all over the world that provide support, education, and advocacy for gay and lesbian parents.

Proud Parenting Magazine
P.O.Box 8272
Van Nuys, CA 91409-8272
e-mail: info@proudparenting.com
WEB: www.proudparenting.com

Gay Parent Magazine
P.O Box 750852
Forest Hills, NY 11375
718-793-6641
e-mail: gayparentmag@banet.net
WEB: www.gayparentmag.com

LGBT Family and Parenting Services
Fenway Community Health Center
7 Haviland Street
Boston, MA 02115
617.927.6243
WEB: www.fenwayhealth.org

Legal Concerns:

Gay & Lesbian Advocates & Defenders
294 Washington Street, Suite 740
Boston, MA 02108-4608
617.426.1350
WEB: www.glad.org

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005-3904
CONTACT: David Buckel
212.809.8585; FAX 212.809.0055
e-mail: LLDEF@aol.com

National Center for Lesbian Rights
870 Market Street, Suite 570
San Francisco, CA 94102
e-mail: info@nclrights.org
WEB: www.nclrights.org

Health and Mental Health Concerns:

Sidney Borum Jr. Health Center
130 Boylston Street
Boston, MA 02116
617.457.8150

Fenway Community Health Center
7 Haviland Street
Boston MA 02115
617-267-9001
888-340-GLBT (4528)

Youth and AIDS Project
University of Minnesota
Adolescent Health Project
428 Oak Grove Street
Minneapolis MN 55403
612-626-2855

Adolescent AIDS Program
Montefiore Medical Center
111 E. 210th St.
Bronx, NY 10467
718-882-0023

Transgender Issues:

IFGE (International Foundation for Gender Education)
PO Box 229
Waltham, MA 02254-0229
781.899.2212
e-mail: IFGE@world.std.com
WEB: www.ifge.org

Harry Benjamin International Gender Dysphoria Association
1300 South 2nd Street, Suite 180
Minneapolis MN 55454
612.625.1500
WEB: www.hbigda.org

Resources for Professionals

Gay and Lesbian Medical Association (GLMA)
459 Fulton Street, Suite 102
San Francisco, CA 94102
415.255.4547; FAX 415-255-4784
e-mail: Gaylesmed@aol.com
WEB: www.glma.org

Gay Lesbian and Straight Teachers Network (GLSTN)
112 West 26th Street, Suite 1100
New York, NY 10001
212.727.0135; FAX 212.727.0254
e-mail: glstn@glstn.org
WEB: www.glstn.org/respect

Society for Adolescent Medicine
Gay and Lesbian Special Interest Group
19401 East 40 Highway, Suite 120
Independence, MO 04055
816.795.TEEN

Lesbian Gay and Bisexual People in Medicine
Committee of the American Medical Students Association
1902 Association Drive
Reston VA 20191
703.620.6600, ext. 458
e-mail: rmichaelis@siumed.edu
WEB: www.amsa.org/sc/lgbpm.html

Association of Gay and Lesbian Psychiatrists
4514 Chester Avenue
Philadelphia, PA 19143
215.222.2800
e-mail: aglpnat@aol.com

American Psychological Association, Committee on Lesbian and Gay Concerns
750 First Street, NE
Washington, DC 20002
202.226.6052

Harvard Gay and Lesbian School Issues Project
Harvard Graduate School of Education
Longfellow Hall 210
Cambridge, MA 02138
617.491.5301; FAX 617.495.8510

In the Family (magazine)
PO Box 5387
Takoma Park, MD 20913
301.270.4771
e-mail: Lmarkowitz@aol.com
WEB: www.inthefamily.com
Articles focus on gay/lesbian parenting issues.

Ryan C. and Futterman D, *Lesbian and Gay Youth: Care and Counseling.* New York: Columbia University Press, 1998.

II. ADDITIONAL INTERNET SITES

Gay and lesbian teen pen pals. http://www.chanton.com/gayteens.html

National resources for lesbian, gay, and bisexual youth.
Http://www.yale.edu/glb/youth.html

Outright. http://outright.com/

Out Proud, National Coalition for Gay, Lesbian, and Bisexual Youth.
http://www.cyberspaces.com/outproud

LGBT youth forums, chat rooms, and brochures.
www.youthresource.com

A discussion group for GLB youth
www.youth.org/ssyglb/

A listing of international groups advocating for GLB youth, listed by country.
www.gaylesTeens.about.com/cs/organizations

Sexual Minority Youth and Family Services.
www.ourtruecolors.org

Youth Guardian Services
www.youth-guard.org/youth/
On-line peer-supervised support groups for lesbian, gay, bisexual and transgender youth, and youth with a lesbian, gay, bisexual or transgender family member. Three age groups: younger teens, older teens, college.

III. HOTLINES

GLBT Youth Peer Listening Hotline
Fenway Community Health Center
617-267-2535
800-399-PEER (7337)

AIDS Foundation Hotline (English and Spanish)
800.FOR.AIDS

Gay, Lesbian, and Bisexual Youth Hotline
800.347-TEEN

Gay and Youth Talk Line
415.863.3636/800.246.PRIIDE

LYRIC Youth Talkline and Infoline
800.246-PRIDE

National Center for Lesbian Rights
800.528.6257
National HIV/AIDS Hotline
800.342.AIDS

National Lesbian and Gay Crisis Line
800.221.7044

IV. PEN PALS SERVICES

Alyson Publications, Letter Exchange Program
40 Plympton Street
Boston, MA 02118

International Pen-Pal Program, Youth Outreach
Los Angles Gay and Lesbian Community Services Center
1625 Shrader Street
Los Angles, CA 90028
213.992.7471

Lambda Youth Network
PO Box 7911
Culver City, CA 90233

Lesbian and Gay Youth Network
PO Box 20716
Indianapolis, IN 46220
317.541.8726

V. NON-FICTION BOOKS

A. Essays, advice for heterosexual parents of a gay or lesbian adolescent

Bernstein R. *Straight Parents, Gay Children: Keeping Families Together.* Thunder's Mouth Press: 1995.
Baker J. *Family Secrets: Gay sons, a mother's story.* Harrington Park Press: 1998.
Borhek MV. *Coming Out to Parents: A Two-Way Survival Guide for Lesbian and Gay Men and Their Parents.* Pilgrim Press: 1993.
Borhek MV. *My Son Eric.* Pilgrim Press: 1984.
Chandler K. *Passages of Pride: Lesbian and Gay Youth Come of Age.* Random Press: 1995.
Cohen S. & Cohen D. *When Someone You Know Is Gay.* Dell: 1989.
Dew RF. *The Family Heart: A Memoir of When Our Son Came Out.* Ballantine: 1995. A very moving account.
Eichberg R. *Coming Out: An Act of Love.* Dulton: 1990.
Fairchild B. & Hayward N. *Now that You Know: What Every Parent Should Know About Homosexuality.* Harcourt Brace Publishing: 1989.
Griffin CW., Wirth AG., & Wirth MJ. *Beyond Acceptance: Parents of Lesbians and Gays Talk about Their Experience.* St. Martin's Press: 1990.
McDougal B. *My Child Is Gay: How Parents React When They Hear the News.* 1998.
Powers B. & Ellis A. *A Family and Friend's Guide to Sexual Orientation: Bridging the Divide Between Gay and Straight.* 1996.
Rafkin L. Different Daughters: *A Book by Mothers of Lesbians.* Cleis Press: 1987.
Savin-Williams RC. *Mom, Dad I'm Gay: How Families Negotiate Coming Out.* 2001.

B. Non-fiction Books for Adolescents

Alyson S. *Young, Gay and Proud.* Alyson Press: 1991.
Bass E. & Kaufman K. *Free Your Mind.* Harper Collins: 1996.
Borhek MV. *Coming Out to Parents: A Two-Way Survival Guide for Lesbian And Gay Men and Their Parents.* Pilgrim Press: 1993.
Chandler K. *Passages of Pride: Lesbian and Gay Youth Come of Age.* Random House: 1995.
Cohen S. & Cohen D. *When Someone You Know Is Gay.* Dell: 1989.
Day FA. *Lesbian and Gay Voices: An Annotated Bibliography and Guide to Literature for Children and Young Adults.* Greenwood Press: 2000.
A superb collection of fiction and non-fiction books for all ages, accompanied by mini-reviews. Profiles of prominent writers of fiction with gay themes.
Fricke A. *Reflections of a Rock Lobster: A Story about Growing Up Gay.* Alyson Publications: 1981.
Harris RH. *It's Perfectly Normal: A Book about Changing Bodies, Growing Up, Sex and Sexual Health.* Candlewick Press: 1994.
Herdt G. & Boxer A. *Children of Horizons: How Gay and Lesbian Teens are Leading a New Way Out of the Closet.* Beacon Press: 1993.

Heron A. *Two Teenagers in Twenty: Writings by Gay and Lesbian Youth.* Alyson Publications: 1994.
Hunt M. *Gay: What Teenagers Should Know About Homosexuality and the AIDS Crisis.* Farrar/Strauss/Giroux Publications: 1987.
Jennings K. *Becoming Visible: A Reader in Gay and Lesbian History for High School and College Students.* Alyson Publications: 1994.
Monette P. *Becoming a Man: Half a Life Story.* Harcourt Brace Jovanovich: 1992 A moving autobiography.
Pollack R. Schwartz C. *the Journey Out: A Guide For and About Lesbian, Gay, And Bisexual Teens.* Penguin Books: 1995.
Powers B. & Ellis A. *A Family and Friend's Guide to Sexual Orientation: Bridging the Divide Between Gay and straight.* 1996.
Sherrill J. and Hardesty C. *The Gay, Lesbian, and Bisexual Students' Guide to Colleges, Universities, and Graduate Schools.* NYU Press: 1994.
Woog D. *School's Out: The Impact of Gay and lesbian Issues on America's Schools.* Alyson Press: 1995.

C. Books for GLB parents

Arnup K. *Lesbian Parenting.* Gynergy Books: 1995. A collection of essays by and about lesbian parents.
Benkov L. *Reinventing the Family: Lesbian and Gay Parents.* Crown Trade Paperbacks: 1994.
Historical review of legal and cultural evolution of gay and lesbian families. Excellent summary and analysis of issues and progress.
Brill S. *The Queer Parents' Primer: A lesbian and gay families' guide to navigating the straight world.* New Harbinger Publications: 2001.
Clunis DM. *The Lesbian Parenting Book; A Guide to Creating Families And Raising Children.* Seal Feminist Publications: 1995.
Drucker J. *Families of Value: Gay and Lesbian Parents and Their Children Speak Out.* Persens Press: 1998.
Glazer DF. & Drescher J. *Gay and Lesbian Parenting.* Haworth Press: 2001.
Green J. *The Velveteen Father.* Ballantine: 1999. A poignant and heart-warming account of the journey to fatherhood.
Howey N. *Out of the Ordinary: Essays on Growing up with Gay, Lesbian And Transgender Parents.* St. Martin's Press: 2000.
Martin A. *The Lesbian and Gay Parenting Handbook: Creating and Raising Our Families.* HarperCollins Press: 1993. A practical guide to many common dilemmas.
O'Connor E. & Johnson SM. *For Lesbian Parents.* Guilford Press: 2000.
Rafkin L. *Different Mothers: Sons and Daughters of Lesbians Talk about Their Lives.* Cleis Press: 1990. Short essays by teenagers and adults.
Rizzo C. *All the ways Home: Parenting and Children in the Lesbian and Gay Communities.* New Victoria Publishers: 1995. A collection of short fiction.
Vercollone C.F., Moss H., & Moss R., *Helping the Stork: the choices and challenges of donor insemination.* MacMillan, New York: 1997.

D. Additional Recommended Non-fiction Books

Boykin K. *One More River to Cross: Black and Gay in America.* Anchor: 1996.
Brown M. & Rounsley CA. *Understanding Transexualism—for Families, Friends, Coworkers, and Helping Professionals.* Jossey-Bass Publishers: 1996.
Casper V. & Schultz SB. *Gay Parents, Straight Schools: Building Communication and Trust*: 1999. Teachers College Press, New York.
Coll C.G., Surrey J.L., & Weingarten K. *Mothering against the Odds: Diverse Voices of Contemporary Mothers.* Guilford Press: 1998.
Essays on mothering, including lesbian, single, and adoptive mothers.
Ettner R. *Gender Loving Care.* WW Norton Co: 1999.
Harbeck K, (ed.) *Coming Out of the Classroom Closet.* Haworth Press: 1992.
Hutchings L. & Kaahumanu L. *Bi Any Other Name: Bisexual People Speak Out.* 1991.
Israel GE. & Tarver DE. *Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts.* Temple University Press: 1997.
Lipkin A. *Understanding Homosexuality, Changing Schools.* Westview Press: 2001.
Lobenstine, G. *Children, Lesbians, and Men: Men as known and anonymous sperm donors.* Alternative Families Project, 442 Warren Wright Road, Belchertown, MA 01007, 1994.
Rothblum ED and Bond LA. *Preventing Heterosexism and Homophobia.* Sage, 1996.
Sears J. & Williams W. *Overcoming Heterosexism and Homophobia*, 1997.

VI. FICTION BOOKS RELATING TO GAY/LESBIAN ISSUES

Ages 2–5

Bosche S. *Jenny Lives with Eric and Martin.* 1983.
Daily life and a birthday party in a family with two dads.

Combs B. *123 A Family Counting Book.*
Combs B. *ABC A Family Alphabet Book.*
Wonderful alphabet and counting books for very young children that incorporate lesbian and gay families naturally into the story.

Edmonds BL. *Mama Eat Ant, yuck*!
About a one year old girl, her two moms and her sister.

Johnson-Calvo S. *A Beach Party with Alexis.* Alyson: 1993.
A light-hearted coloring book that includes friends and family of many colors and sexual orientations.

Kennedy J. at al. *Lucy goes to the Country.* 1998.
A humorous story about a cat who lives with two gay men, various escapades.

Newman L. *Belinda's Bouquet.*

A girl wonders if she is too fat but her friend's two moms tell her that everyone is fine as they are.

Newman L. *Heather Has Two Mommies.* 1999.
One of the first stories for young children about growing up with lesbian moms. Has stirred up a lot of controversy.

Skutch R. Nienhaus L. *Who's In a Family*? Tricycle Press: 1995.
Charming look at various family forms for children from 3 up.

Valentine J. *One Dad Two Dads Brown Dad Blue Dads.* Alyson: 1994.
Charming Seuss-like rhyming book that incidentally includes two dads.

Valentine J. *The Daddy Machine.* Alyson Press: 1992.
A whimsical book describing the machine built by two children with lesbian moms who wonder what it would be like to have a dad.

Valentine J. *Two Moms, the Zark, and Me*, 1993.
A little boy with two moms gets lost, until a magical creature named a Zark helps him out.

Wickens E. *Anna Day and the O-Ring*
Photographs of a little boy, his two moms, and his dog in a very sweet story.

Willhoite M. *Daddy's Roommate.* Alyson Press: 1990.
A sweet story about a little boy talking about his dad and his dad's partner.

Willhoite M. *Daddy's Wedding.* 1996.
A sequel to the book above, in which the boy is the best man at his dad's commitment ceremony

Ages 6 to 10

Abramchik L. *Is Your Family Like Mine*? 1996.
A little girl with lesbian moms explores differences among families.

Alden J. *A Boy's Best Friend.* 1993.
A little boy gets a birthday surprise from his two moms.

Arnold J. *Amy Asks a Question ... : Grandma – What's a Lesbian*?
Probably the first book about lesbian grandparents.

Carrera SJ. *The Families Book: True Stories About Real Kids and the People They Live With and Love.*

Cohen S. *All Families are Different.* Prometheus Books: 2000.

Edmonds BL. *When Grown-Ups Fall in Love.*
A sweet poem that is inclusive of same sex parents.

Elwin R. Paulse M. *Asha's Mums.* Women's Press: 1990.
A first grade girl has to educate her teacher and her classmates about her lesbian moms.

Gordon S. *All Families are Different.* 2000.
Affirmation of a variety of family structures, including adoptive and foster families, multiracial families, and same sex parents.

Heron A. & Maran M. *How Would You Feel if Your Dad Was Gay*? Alyson Press: 1991. Michael and Jasmine have two gay dads and Noah has a lesbian mom in this story in which all three have to deal with homophobia at their school.

Hoffman E. *Best Best Colors/Los Mejores Colores.* Redleaf Press: 1999. In English and Spanish, the little boy has trouble deciding which is his favorite color. His two moms help him learn that he doesn't have to choose just one.

Jenness A. *Families: A Celebration of Diversity, Commitment and Love.* 1993.

Seventeen young people describe many different kinds of families. Illustrated by wonderful photographs.

Jordon MK. *Losing Uncle Tim.* Albert Whitman & Co.: 1989.
A beloved uncle dies of AIDS.

Newman L. *Saturday Is Pattyday. 1993.*
A young boy worries about how he will maintain his relationship with his two moms when they get divorced. They reassure him that they will always be his family.

Nones E. *Caleb's Friend.* Farrar, Straus & Giroux, 1993.
The tender and caring bond between two boys is celebrated with exquisite paintings and lyrical text.

Tax, M. Families. *Feminist Press*: 1996.
Six year old girl introduces her multicultural friends and their families which take many forms—adoptive, divorced, stepfamilies, and same-sex families.

Valentine J. *The Duke Who Outlawed Jelly Beans.* Alyson Publication: 1991. A collection of fairy tales in which the children all have gay or lesbian parents.

Early adolescence (11–14)

Barger G. *What Happened to Mr. Forster*? Clarion Books: 1981.
Set in the Midwest in 1958, the story is of a beloved teacher who is fired for being gay.

Brett C. *S.P. Likes A.D.* The Women's Press: 1989.
A teenage girl who is in love with a female classmate.

Durbin P. & Feldman S. *And Featuring Bailey Wellcom as the Biscuit.*
A young girl discovers that her mother is a lesbian and in a relationship with another woman.

Garden N. *Holly's Secret.* 2000.
A girl moves to a new town and tries to hide the fact that she has two moms—getting herself into a lot of trouble in the process.

Greenberg KE. *Zach's Story: Growing Up with Same-Sex Parents.* Lerner Publication: 1996.
A story told by 11 year old Zach who has two lesbian moms.

Hesse K. *A Time of Angels*,
The girl who narrates the story about the flu epidemic in World War I is being raised by two women who are a couple.

Nelson T. *Earthshine: A Novel.* Orchard: 1994.
A 12 year old girl lives happily with her actor father who is gay and his partner, but must learn how to cope with loss when she learns that he has AIDS.

Salat C. *Living in Secret.* Bantam Skylark: 1993.
Lesbian mother kidnaps her 11 year old daughter after custody is awarded to the father, so that she can continue to live with her mother and her partner. Addresses racism, legal rights of children, and custody.

Adolescents

Bauer MD. *Am I Blue: Coming Out from the Silence.* HarperCollins: 1994.
Short stories dealing with homosexuality; the title story is especially delightful.

Bechard, M. *If It Doesn't Kill You*, Viking: 1999.
Story of a high school freshman whose father comes out as gay. Includes a sensitive explanation to his son of his recently recognized homosexuality.
Block, F. *Weetzie Bat.* Harper Collins: 1989.
Block F. *Baby Be-Bop*, Demco: 1997.
Block F. *Witch Baby*, Harper Collins: 1992.
Three delightfully absorbing books that use imagination and fantasy to address issues about gayness, fitting in, and diversity.

Brown, T. *Entries from a Hot Pink Notebook.* Pocket Books: 1995.
A teenage boy comes to understand his homosexuality and the homophobic high school he attends as he records his thoughts in a pink notebook.

Cart, M. *My Father's Scar.* Simon and Schuster, 1996.
During his first year in college the protagonist reflects on his dysfunctional family and his sadness growing up.

Garden N. *Annie on My Mind.* Farrar, Strauss & Giroux, 1982.
Delightful love story about two teenage lesbians.

Garden N. *Good Moon Rising.* Farrar, Straus and Giroux, 1996.
Teenage lesbian actress helps to direct a play in which she had wanted to perform—and falls in love with the girl who is playing the part she had wanted.

Guy R. *Ruby.* Viking: 1976.
African-American teenage girl falls in love with a female classmate.

Kerr, ME. *Deliver Us From Evie.* Harper Collins: 1994.
A 16 year old farm boy learns that his sister is a lesbian and in love with the daughter of a prominent town leader.

Kerr, ME. *Night Kites.* Harper and Row: 1986.
A heterosexual teen finds out that his older brother is gay and has AIDS.

Koertge R. *The Arizona Kid.* Little Brown: 1988.
A heterosexual teenage boy visits his gay uncle, learns about training horses and has a short romance with an exercise girl, gets a glimpse of gay life in the early days of AIDS.

Mosca F. *All American boys.* Alyson Publications: 1983.
A coming out and love story between two teenage boys.

Murrow, L. Ketchum. *Twelve Days in August*, 1993.
Deals with homophobia from the perspective of a heterosexual adolescent who struggles with loyalty in the face of homophobia.

Sinclair, A. *Coffee will make you Black, 1994.*
Story of a young adolescent in a working class urban family struggling with issues of racial and sexual identity.

Singer B. *Growing Up Gay/Growing Up Lesbian: A Literary Anthology.* New York Press: 1994.
An anthology of essays and stories mostly about the coming out process.

Walker K. *Peter.* Houghton Mifflin: 1993.
Fifteen year old boy's struggles with his emerging sexual identity.

Winterson J. *Oranges Are Not the Only Fruit.* Atlantic Monthly Press: 1997.
Describes the development of a lesbian teenager in the context of a fundamentalist household; funny, delightful and wise.

Wittlinger E. *Hard Love.* Simon & Shuster, *1999.*
A teenager, John, who isn't sure if he is gay, straight, or "neutral', becomes friends with zine creator Marisol, who is a lesbian—and falls in love with her.

Woodson J. *The House You Pass on the Way.* Delacorte: 1997.
Charming story of a 14 year old girl who struggles with her emerging confusion about her sexual orientation.

VII. SOURCES FOR MATERIALS

Lambda Rising Bookstores
1625 Connecticut Avenue, NW
Washington, DC
202.462.6996; Toll-free: 1.800.621.6969; FAX 202.462.7257
e-mail: lambdarising@his.com

WINGSPAN MINISTRY (posters)
St. Paul-Reformation Lutheran Church
100 North Oxford Street, St. Paul, MN 5510406540
651.224.3371; FAX 651.224.6228
e-mail: WNGSPAN@aol.com
WEB: www.stpaulref.org/wingspan.htm

Donnolly-Colt (buttons, rainbow stickers, etc.)
860.455.9621; FAX 1.800.553.0006
e-mail: donco@neca.com

Indiana Youth Group (poster)
P.O.Box 20716
Indianapolis IN 46220
317-541-8726
WEB: www.indianayouthgroup.org

VIII. PAMPHLETS

Available from PFLAG, Washington DC

Our *Daughters and Sons: Questions and Answers for Parents of Gay, Lesbian and Bisexual People.* 1995

Be yourself: Questions and Answers for Gay, Lesbian, and Bisexual Youth. 1994.

About Our Children

Can We Understand?

Teens Tell Their Own Stories

Why is My Child Gay?

Available from Family Pride Coalition, Washington DC

Guide to Talking to Children about our families. 2001

Available from Kaiser Permanente, Oakland, CA

A Provider's Handbok on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered population. 2000

Available from the American Psychological Association, Washington D.C.

Answers to your questions about sexual orientation and homosexuality.

IX. VIDEOS

Straight From the Heart: Stories of Parents' Journeys to a New Understanding Of Their Gay and Lesbian Children. Dee Mosbacher. 1994. Motivational Media, 8430 Santa Monica Blvd., Los Angles, CA 90069, (800)848-2707 Parents talk about their lesbian and gay children. 24 minutes.

Queer Son: Family Journeys to Understanding and Love. Vickie Seitchik. 1994. 19 Jackson St., Cape May, NJ 08204 (212)929-4199 A compelling personal documentary with interviews of families from diverse ethnic, racial, and social backgrounds. 48 mins.

Both of My Moms' Names are Judy. Lesbian and Gay Parents Association, 1994. Family Pride, P.O. Box 43206, Montclair, NJ 07043 (202)583-8029 A racially diverse group of 6-10 year old children talking about their love for their gay and lesbian parents. 10 minutes.

Gay Youth: An Educational Video for the Nineties. Pam Walton. 1992. Wolfe Video, Box 64, New Almaden, CA 95042 (408)268-6782 A documentary highlighting two teens' stories—one with a positive outcome, one a suicide; won an award. For adolescent and adult audiences. Comes with a study guide. 40 minutes.

Just for Fun. Gordon Seaman. 1994. Direct Cinema Limited, P.O. Box 10003, Santa Monica, CA 90410-1003, 1-800-525-0000 Stimulating drama examining homophobia and gay-bashing. 24 minutes.

Sticks, Stones, and Stereotypes. Cindy Marshall, Equity Institute. 1988. ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830, 1-800-321-4407 Discussion of homophobia, name-calling for high school and college viewing. Comes with a study guide in English and Spanish. 26 mins.

Too *Close . . . for Comfort.* Wild Ginger Productions. 1990. ETR Associates. P.O. Box 1830, Santa Cruz, CA 95061-1830, 1-800-321-4407 Deals with fear of AIDS, homophobia and discrimination. Appropriate for high school. 27 mins.

From a Secret Place. Karin Heller and Bill Domonkos. 1994 Fanlight Productions, 47 Halifax St., Boston, MA 02130, (617)524-0980 Interviews with six gay and lesbian teens and three parents by a therapist. 40 Mins.

I Just Want to Say. GLSEN. 1998. Addresses anti-gay violence and stigma in high schools. 14 mins.

I know who I Am ... Do You? Louis Pereg. Skyline Community. 1998.
Black and Latino gay youth who are successful despite discrimination and other struggles. 10 mins.

It's Elementary: Talking About Gay Issues in School. Women's Educational Media. 2180 Bryant St., Suite 203, San Francisco, CA 94110. 415.641.4616 Explores the teaching and understanding of diversity and tolerance in elementary school classrooms. 78 mins.

Our House. Sugar Pictures 1999. Documentary featuring the children of 5 diverse families facing varied reactions to their parents' sexual orientation. 56 mins.

That's a Family! Women's Educational Media. 2000. Children discuss various family forms: adoption, mixed-race families, same-sex parents, divorce, and single parent families. Comes with a curriculum guide for use in elementary classrooms. 30 mins.

Trevor. Peggy Rajski. 1998. Follows a 13 year old as he reads from his diary. When his classmates learn that he is gay they ostracize him and he attempts suicide. The supportiveness of a hospital volunteer inspires him. The film sparked a project to promote tolerance and prevent suicide. 23 mins.

DeGrassi Junior High: He ain't heavy. WGBH, Box 222-TV, South Easton, MA 02375. A 14 year old boy learns that his older brother is gay.

DeGrassi Junior High: Rumor has it. WGBH, Box 222-TV, South Easton, MA 02375. A young girl struggles to understand her own sexuality when she learns that a favorite teacher is lesbian.

Homo Teens. Available from Joan Jubila, PO Box 1966, New York, NY 10013. Five very different teens speak for themselves.

Sexual Orientation. Wisconsin Public Television's Cooperative Education Service Agency, 800.622.7445.

Out: Stories of Lesbian and Gay Youth. 1993. National Film Board of Canada, 1251 Ave. of the Americas, 16th floor, New York, NY 10020. 212.596.1770. A sensitive look at the lives of a cross-section of gay and lesbian teens and their families.

Boys *Don't Cry.* Moving commercial film exploring the pain of homophobia and gay-bashing.

Ma Vie en Rose. Sad depiction of a boy with gender-atypical behavior and passions and the conflicts created in the family. Commercial film.

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