Sexual Orientation Curricula:
Implications for Educators

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Abstract

Programs to eliminate heterosexism recommended for use in the BC public school system curricula would require educators to teach children that homosexuality and bisexuality are normal, safe and acceptable forms of sexual expression in human relationships, equivalent to heterosexuality. This paper will demonstrate that the data supporting homosexuality as a normally occurring, inherent condition are inconclusive, and that data supports the concept that homosexuality results from abnormal psychosocial development. Treatment success for those wishing to change their orientation is high with a variety of therapeutic techniques.

Introduction

On March 16, 1998, delegates to the BC Teachers' Federation Annual General Meeting affirmed a comprehensive set of guidelines designed to implement programs to reduce so-called homophobia and heterosexism. The initiative was endorsed in principle at the March, 1997 AGM after lobbying from the Gay and Lesbian Educators of BC (GALE-BC). The measures included having gays or lesbians instruct teachers and students in the area of homosexuality, asking universities and the BC College of Teachers to require that student teachers have anti-homophobia/ heterosexism instruction as a requirement in all teacher education programs, lobbying government to enact legislation to prevent school boards from vetoing curriculum materials related to alternate forms of sexuality, and lobbying to have sexual orientation issues as a curriculum item in all subject areas from kindergarten to grade 12 (BC Teachers Federation, February, 1998).

While most people would agree that reducing harassment or hatred of any minority group is a good goal, presuming that all of society is ready to agree that homosexuality and bisexuality are healthy, normal, acceptable, and morally equivalent to heterosexuality is controversial to say the least. This paper will demonstrate that the improved social image of these forms of

sexuality are due more to effective lobbying and misuse of questionable research, than to conclusive evidence as to the normalcy of homosexuality.

HIV/AIDS and STD Infection Risks

Teaching children that the homosexual lifestyle is normal and healthy would be highly irresponsible and would contradict curriculum requirements to teach children to avoid risks of acquiring STD's. The tremendous health risks associated with homosexual behaviours are well documented. For example in the U.S. only 9% of AIDS cases are due to heterosexual contact or blood transfusions (2%), while the balance of infections are from homosexual/bisexual activity and intravenous drug abuse (Centers for Disease Control, 1994). In Canada, over 90% of male AIDS cases are due to homosexual or bisexual activity (Health Canada, December, 1996).

Men who have sex with other men (MSM) are four times as likely to become infected with HIV as any other group (Strathdee *et al*, 2001). Over 260,000 American homosexual men have died of AIDS, a total greater than for all other groups combined (Wolitski *et al,* 2001). Wolitski also found that 18% of the gay men in his study were HIV positive, versus 1% for the population as a whole. Another serious health concern is that of anal cancers. Gay men are 24 times as likely to acquire this deadly disease, likely due to the immuno-suppressant properties of semen deposited in the rectum combined with genital warts, a known pre-cancerous agent (Koblin *et al,* 1996).

A 1999 health survey of lesbian, gay, bisexual and transgendered youth in British Columbia found that LGBT youth were more than three times as likely to have ever had an STD (McCreary Centre Society, 1999). Infection rates for gonorrhea, syphyllis, genital warts, hepatitis A, B & C, herpes, chlamydia, and enteric parasites associated with sexual-oral contact with fecal matter, are all higher for MSM (Cameron, Cameron & Proctor, 1989).

Promiscuity and High Risk Behaviours

Health Canada (2000), in study of the high risk behaviours of young gay men in Vancouver, found that 40% of them had engaged in "barebacking" or unprotected receptive anal intercourse in the past year. This is alarming given the evidence found by Dr. Bill Darrow of the US Centers for Disease control. In a study conducted in south Florida, Dr. Darrow found that 75%

of HIV positive men, who knew they were infected, engaged in unsafe sex anyway (in Jonas, August 27, 1997). Another study reported in the *New England Journal of Medicine,* showed that only 7% of HIV positive men were voluntarily notified of their infection by a sex partner (in Gairdner, 1992). This statistics make it clear that homosexual men are not acting responsibly in their sexual behaviour, despite millions of dollars of public education in the past 20 years promoting "safe" sex.

Anal sex and multiple sex partners, which are common features of male homosexual behaviour, are very high risk activities and have led to high rates of HIV infection among the gay community. Indeed, gay people with AIDS average more than 1, 100 lifetime partners accord to a 1982 study by the US Centers for Disease Control. A comprehensive study done prior to the AIDS epidemic found that the average gay man had 500 different "lifetime" partners, while 28% reported more than 1000 partners. Moreover, 79% of gay men in the same study said more than half their partners were total strangers (Bell & Weinberg, 1978).

One study asked gay men to keep sexual diaries of their partners and activities for a year. The study, published in the *NewEngland Journal of Medicine,* showed that these men *averaged* 100 sexual partners annually (Corey & Holmes, 1980). Homosexual men are four times more than heterosexuals to have had more than 100 sex partners (Patterson & Kim, 1991). Similarly, gay youths in British Columbia were four times as likely as heterosexual youths to have had three or more sexual partners in the past three months (McCreary Centre Society, 1999).

While studies have confirmed that a majority of asymptomatic gays are changing their behaviours in response to the risk of AIDS, 70% still admitted a continuation of sexual practices that would expose them to HIV infection (Siegel *et al,* 1988). What is more disturbing is that Siegel found that for every two men changing to safer practices, one respondent shifted from safer to *riskier* sexual behaviour.

High risk behaviours are those which cause fissures or tears in an orifice, thus providing the HIV virus, or other microbial agents access to the bloodstream. The risk is particularly high in the rectum, where there is only a one cell layer between the inner surface and the blood supply. Thus, HIV is most prevalent in people who engage in unprotected receptive anal intercourse, receptive fellatio, analingus (termed "rimming" by the gay

community), and receptive fisting (insertion of the entire fist into the rectum), and those who do so with muliple partners (Allgeier & Allgeier, 1995).

Even gay men who choose safe sex in their voluntary relationships can't always count on being safe. Date rape, a serious problem in the heterosexual community, appears to be even more prevalent among gays. In a nationwide (US) anonymous survey, 20% of women reported a date rape, but over 37% of gay or bisexual men revealed that they had been raped by men they knew (Patterson & Kim, 1992).

A high number of multiple anonymous partners may be evidence of a sexual addiction. Sexual addictions have been successfully treated with 12-step programs similar to those used by Alcoholics Anonymous (Carnes, 1984). A variant of this program, 32 weeks in duration, is used by Exodus International, a organization operated by former homosexuals to assist those with unwanted same sex attractions to revert to heterosexuality (Hopper, May 2, 1997).

Orientation and Mental Disorders

Although it has been over 30 years since homosexuality has been removed from the manual of psychiatric disorders, there is increasing evidence that mental disorders are much more highly correlated with non-heterosexual orientations. J. Michael Bailey, in a commentary on the mounting research data finding that correlation noted, "These studies contain arguably the best published data on the association between homosexuality and psychopathology, and both converge on the same unhappy conclusion: homosexual people are at substantially higher risk for some form of emotional problems, including suicidality, major depression, anxiety disorder, conduct disorder, and nicotine dependence" (Bailey, 1999).

A New Zealand study followed a large group of young people from their birth to their early twenties. This highly regarded longitudinal study showed a significantly higher occurrence of depression, anxiety disorder, conduct disorder, substance abuse, and suicidality among those of homosexual or bisexual orientation (Ferguson *et al*, 1999). Ellis *et al* (1995), found that 38% of the homosexual men seeking service at an STD clinic showed evidence of antisocial personality disorder, far above the 2% rate for the general population. A study published in the *American Journal of*

Psychiatry (Carlat *et al*, 1997), found that 43% of a bulimic sample of men were homosexual or bisexual—15 times the rate in the general population.

But one of the most significant recent studies was conducted in the Netherlands by Sandfort and his colleagues (2001). The study showed elevated rates of mental illness for homosexual men and lesbians, including depression, anxiety disorders, obsessive-compulsive disorders, and substance abuse addictions. The study is significant because gay lobbyists have alleged that negative social attitudes towards homosexuality are a prime causal factor for mental problems among gays and lesbians—yet Holland is arguably among the most gay positive countries on the planet. Furthermore, cross cultural studies have shown that the admittedly higher levels of hostility towards gays in the United States does not lead to a corresponding higher incidence of mental illness in homosexuals, compared with incidence rates in more tolerant societies in Denmark and the Netherlands—the rates are similar (Ross, 1988). In other words, concluding that "homophobia" is a cause of mental health problems among gays is simply not warranted.

Relationship Instability and Attitudes towards Monogamy

How common is monogamy or even "faithfulness" among homosexuals who live together? Gay researchers (*The Male Couple)* David McWhirter M.D. and Andrew Mattison M.S.W. Ph.D., a couple themselves, found that less than 5% of gay men could be classified as monogamous and not one of the relationships in their study group had maintained fidelity for more than 60 months (Marcus, 1988). Bell & Weinberg (1981 in Marco, 1996) found that only 3% of gay men had had fewer than 10 "lifetime" sexual partners and could class only 2% as monogamous or "partially monogamous".

The majority of heterosexuals in permanent relationships are rarely promiscuous. Approximately 60% of married are exclusively monogamous, while an additional 25% are primarily monogamous. Fifteen per cent report regular extramarital liaisons (Carter, 1990). A University of Chicago study (1990) determined that the estimated number of lifetime sexual partners since age 18 for the U.S. population as a whole is 7.15 and only 8.67 for those who never marry.

Indeed, the monogamy held as an ideal in heterosexual relationships appears to be "culturally unacceptable" to gay men. When researchers in San

Francisco recommended to their study group participants that restricting themselves to one partner would reduce their health risks, they demurred, saying monogamy "lacked creativity and showed a lack of understanding of an outsider to the gay lifestyle" McCusick *et al*, December, 1985).

Suicide Risk

The high suicide rate among gay youth is a prime rationale for implementing homosexual-friendly programs in schools. This conclusion is based in part on questionable data reported by gay San Francisco social worker and activist Paul Gibson as part of a 1989 report of a special federal task force on suicide prevention. Gibson clamed that over 30% of youth suicides are committed by gay youth, that it was their leading cause of death, and that their suicides were caused in part by "internalization of homophobia" (Gibson, 1989).

Gibson collected data from gay-run drop-in centers for homeless youth in large U.S. cities, then used the dated and discredited Kinsey data on the number of gays in the population to extrapolate his figures to the whole population (LaBarbera, 1996). He did not submit his data to rigorous peer review and his "essay" contained more "hocus pocus" that new research data, according to David Shaffer, a Columbia University psychiatrist and specialist on adolescent suicide (Shaffer, May 3, 1993). Bell & Weinberg (1978) found that the most common reported cause for a suicide attempt (47%) was a dispute with a lover.

The most common reason listed among gay youth in British Columbia was "feeling lonely and isolated", followed by "problems with parents" [unrelated to orientation issues]. Rejection by school friends due to orientation tied for last place is a list of 10 reasons for a suicide attempt (McCreary Centre Society, 1999).

It is not surprising that some distressed and homeless gay youth would be feeling despondent and suicidal, but Gibson's statistics alleging a causal relationship between homophobia, internal or external, have not stood up to any scrutiny by experts in suicide research. Naturally, it is difficult to determine precisely which combination of causes lead to a completed suicide, but the impact of relationship instability, failure to establish a long term emotionally nurturing relationship, clinical depression, and the impact

of chronic health problems due to HIV or hepatitis infection, are certainly worthy of further research.

A 1991 survey by Gallup of 1152 teenagers showed that 15% had attempted suicide, but in an open-ended question, not one stated it was due to issues related to sexual orientation (Gallup, January, 1991). An unpublished study of 64 high risk youth in Seattle by University of Washington researcher Leona Eggert found only one respondent who gave his sexual orientation as the prime motivator of his suicide attempt (in LaBarbera, 1996). Patterson & Kim's (1991) survey of 2000 anonymous respondents revealed that 32% of heterosexuals versus 37% of homosexuals had contemplated suicide. Given the 3.1% margin of error in the figures, there was statistically no difference in suicide ideation between the orientations.

Other studies have found a higher prevalence of self-harm inclination and other psychological problems among homosexuals, though. A recent study of 946 men and women in New Zealand, conducted over 23 years, found that self-harm and suicidal behaviour was higher among same sex attracted individuals. The greater the level of same sex attraction, the higher the levels of depression, increased substance abuse, and intentional self-inflicted harm (Skegg *et al,* March 2003).

A British study comparing heterosexual men and women to their homosexual counterparts (n=2,179) was recently published in the *British Journal of Psychiatry* (King *et al*, 2003). It is a significant study because no previous European study had recruited over 1000 homosexual men and women. The researchers found that homosexual men and women consulted mental health professionals more, that lesbians were more prone to be victims of violence and physical intimidation, and to drink excessively, and that both genders tended to score higher on scales of psychological distress. The authors commented that "gay men and lesbians may have lifestyles that make them vulnerable to psychological disorder. Such lifestyles may include increased use of drugs and alcohol" (King *et al*, 2003).

Interestingly, the study found that school bullying was experienced no more often by gay men than heterosexual men, calling into question one of the primary rationales for gay-friendly school programs, i.e. that gays are disproportionately targeted for bullying (King *et al,* 2003). Nevertheless, gay and lesbian young people are more prone to have poorer mental and

physical health, and engage in higher levels of sexual risk taking than self-identified heterosexual adolescents (Lock & Steiner, 1999).

Longevity

A major Canadian study found that the lifespan of homosexual men was 8 to 20 years less than that of heterosexual men. The authors noted that gay men have about the same life expectancy of Canadian men in 1871 (in Daily, 2003).

Another study examined the actual obituaries from 18 American homosexual periodicals for a 13-year period, and compared them to the obituaries from regular newspapers. The median age of age of married, never divorced men was 75 and 80% of them died old (i.e. age 65 or older). For unmarried or divorced men the median age of death was 57 and 32% of them died old. Married, never-divorced women died at age 79 on average and 85% died old. Unmarried and divorced women averaged age 71 and 60% of them died old (Cameron *et al,* 1994).

The median age of death for homosexual men, if the death was due to something other than AIDS, was 42 (9% died old). If AIDS was the cause of death, the average age was 39. It wasn't much more for lesbians: the median age was 44 (20% died old). 18% of lesbians died of murder, suicide or accidents, a rate 456 times higher than white heterosexual females aged 25-44 (Cameron *et al*, 1994). Evidently, the lifestyle practiced by many in the homosexual community puts them at high risk for a shortened lifespan.

Overall Incidence of Homosexuality in the Population

The homosexual movement's assertion that 10% of the population is homosexual is simply false. This figure is based on the dated (1948) study by Alfred Kinsey. Kinsey asked his subjects if they had participated in any homosexual activity in the past three years (1945-1947). Incredibly, 26% of Kinsey's 5300 subjects were male prison inmates, including sex offenders (Pomeroy, 1972). Other subjects were recruited from less than neutral locations, such as gay bars in Chicago. His statistics were not valid in 1948, and are certainly not so 50 years later.

A highly regarded nationwide sexuality survey by Laumann *et al* (1994), conducted at the University of Chicago, found that the incidence of recent

homosexual activity among men was 2.8% and 1.4% for women. "Full time" practitioners of homosexuality formed between one and 1.3%. In adolescents, rates for homosexuality are even lower (0.7% for boys, 0.2% for girls), according to a study in Minnesota public schools with a massive sample size of 36,741 (Remafedi *et al*, April, 1992).

Findings with almost identical percentages have been ascertained in other countries such as Britain (Johnson *et al*, December 3, 1992) and France (Spira *et al*, November 22, 1990) as well. A study of over 5000 Canadian college students reported homosexuality rates of 1.7% (McCormick in Social Action Commission, 1993). A survey of over 15,000 British Columbia adolescents found that less than 1% identified themselves as homosexual (McCreary Centre Society, 1993). And the 2001 Canadian census, which asked citizens to identify their orientation for the first time, found that only 1.3% of men and 0.7% of women listed themselves as homosexual or bisexual. The combined amount for people aged 18-59 was 1.0% homosexual and 0.7% bisexual (Statistics Canada, June 15, 2004). Despite this overwhelming international data, publications endorsed and distributed by the BC Teachers Federation for use as teaching resources still reference inflated and unattributed figures (GALE-BC, 1995; GALE-BC, 1998).

Homosexuality: Nature or Nurture

The belief that homosexuality is an inherited, immutable behavioural trait has not been convincingly demonstrated. The study cited most often was one where neurologist Simon LeVay (1991) found that the hypothalamus of 19 men who died of AIDS were measurably different than 16 "assumed heterosexual" brains. A gay newspaper reporter uncovered LeVay's sloppy research methods, however, when he had to admit that he did not know for certain the sexual orientation of any of his control group subjects—he simply assumed that their orientation was heterosexual (Botkin, September 5, 1991).

While this should have invalidated the study, which had an extremely small sample size in any case, the popular press (*Newsweek,* February 24, 1992), announced the discovery of "homosexual brains" (in Marco, 1996). Moreover, since approximately 25% of those who die from AIDS suffer neurological dementia, hypothalamus anomalies could be attributable to the disease itself (Marco, 1996).

The identical twin studies which purport to show a correlation between homosexuality and X-chromosome markers (Hamer *et al*, 1993) have been criticized for the lack of a control group of identical twins reared apart, and an inadequate number of subjects to extrapolate the conclusions to the general population.

In fact, other genetics research experts at Columbia University (King & McDonald, 1992) and Harvard (Billings & Beckwith, July, 1993), who found evidence similar to Hamer's, concluded that identical twin studies actually provide strong evidence of the influence of the environment rather than genetics in homosexual development. Billings & Beckwith rather caustically call Hamer's research "molecular phrenology" (in Satinover, 1996a). And an attempt to replicate Hamer's results by his colleague, Dr. Alan Sanders, failed. Stated Sanders, "Although the original study found evidence for genetic linkage, ours does not" (Byfield & Byfield, June 15, 1998).

Ironically, even the *Journal of Homosexuality* now does not support "gay-gene" theory or "gay-brain" theory (Socarides, 1996). Gay activists are now moving to have homosexuality viewed as a celebration of personal empowerment and freedom rather than a biological imperative. Sociologist Ira Reiss advocates for a sexual pluralism to root out the narrowness of heterosexism in all of society's institutions, including schools, families and churches (Reiss, 1990 in Marco, 1996). Lesbian activist Donna Minkowitz write, "Homophobes…are right when they say that we threaten the family, male domination, and the Calvinist ethic of worth…that has paralyzed most Americans' search for pleasure (April 1, 1996). Clearly, this is a hedonistic philosophy whose goals run contrary to what many heterosexual families value.

A number of studies support the concept of "malleability" of erotic attraction, especially for lesbians (Rosik, January, 2003). The studies have reported that 31% to 50% of lesbians consider their sexual orientation to be the result of a conscious, deliberate choice (Rosenbluth, 1997; Whisman, 1996). Apparently, fluidity of attraction is more a factor among lesbians than homosexual men, however.

Psychosocial Influences

Sexual identity has been shown to be highly influenced by cultural learning. "That we are sexual is determined by a biological imperative towards reproduction, but how we are sexual—where, when, how often, with whom, and why—has to do with cultural learning, with meanings transmitted in a cultural setting (Fracher & Kimmel, 1992).

The dynamics of human psychosexual development appropriate to gender have been studies in considerable depth with much emphasis played on positive self esteem and the development of the capacity for intimacy and ego strength in childhood (Freud, 1953/1981; Miller & Simon, 1980). How sexual feelings and interests are expressed is a result of the young person's inherited temperament, gender, their impact on members of their family, including extended family, the feelings, attitudes, experiences and behaviours of family members towards "significant others" outside the family, the nature of the family system, and the interaction of all family members with the larger environment (Chillman, April, 1990).

Gender role non-conformity in childhood has been indicated to have a strong correlation with adult homosexual behaviour by a number of researchers, (Baily, Miller & Willerman, 1993; Bell, Weniberg & Hammersmith, 1981: Green, 1987; Nicolosi, 1997; Phillips & Over, 1992; Whitam, 1977). As children, homosexual men were much more likely to have been involved in behaviours stereotypically female, such as cross-dressing, preference for the company of female friends, adoption of female roles in sex play, and preference for girls' games and activities (Whitam, 1977). Nicolosi has found in his work with gender identity disordered boys that they tend to become infatuated with role playing female Disney characters, such as Little Mermaid or Cinderella (Nicolosi & Nicolosi, 2001). Indeed, Whitam (1977) found that 97% of homosexuals in his study reported one or more of these experiences, while most heterosexuals (79%) did not.

The role of early sexual experiences has also been demonstrated to influence orientation. A detailed analysis of Kinsey's 11,000 subjects (1938-1963), showed that intense sexual experiences, feelings of arousal, pleasure or discomfort associated with early experiences, were the strongest correlates of adult sexual orientation (Van Wyk & Geist, 1984). Van Wyk also found that those boys who learned to masturbate by being masturbated by another male were much more likely to be attracted to men in adulthood. A similar

correlation was also found for those whose first orgasm occurred through homosexual contact.

While homosexual contact for boys appears to influence adults homosexuality, the reverse appears to be true for adult lesbians. Bell and Weinberg (1978) found that while only 20% of gay men engaged in heterosexual intercourse prior to adopting a primarily homosexual identity, 85% of lesbians had prior heterosexual experience. Van Wyk & Geist's data (1984) offer support for the concept that adults lesbians were much more likely that heterosexual women to have had pre-pubertal sexual contact with adult men.

One significant item for counselor educators from Van Wyk's research was the correlation between the age of learning about homosexuality and adult orientation. The mean age of learning about homosexuality for females predominantly homosexual as adults was 13.9 years, while who were primarily heterosexual was 19.4 years (which sounds "late", but is understandable given that the data is from Kinsey's 1938-63 subject base). For boys, adult homosexuals' mean age of learning about homosexuality was 12.0 years, while the mean age for adult heterosexuals was 16.4. Basically, the data suggests that the earlier a child learns about homosexuality, particularly through experiential learning, the greater the likelihood of adopting homosexuality as an adult orientation (Van Wyk & Geist, 1984).

Impact of Pedophilia

Childhood sexual experiences that are abusive also appear to be correlated with development of orientation. Finkelhor *et al* (1990), in a national phone sample of 1145 men, reported that 9.5% confirmed being the target of unwanted completed or attempted sexual intercourse prior to age 19, and that 80% of the perpetrators were of the same sex as the victim. However, Dell *et al* (1992) found that 37% of 1001 homosexual and bisexual men reported being abused as children, 94% of them by older males. Their median age of abuse was age 10, while their abusers averaged 11 years older. Doll's results appear to support the findings of Van Wyk & Geist (1984), that same sex experiences in childhood are correlated with adult orientation. Forty per cent of gay youth surveyed indicated that they had been sexually abused, versus 12% for heterosexual youth (McCreary Centre Society, 1999). While further research is clearly warranted, these statistics

appear to implicate pedophilia as a factor in the psychosocial development of youth and adult homosexuality.

The incidence of adult homosexuals who were childhood victims of pedophiles is strongly supported by data showing that those of homosexual or bisexual orientation are much more likely to commit child molestation. A review of 19 separate studies exploring the ratio of heterosexual-to-homosexual molestation of children found that those who practice homosexuality are 12 times more likely than heterosexuals to sexually assault a child, and bisexuals were 16 times as likely to do the same (Cameron, 1985).

This statistic is also support by data in the *Report to Members* of the British Columbia College of Teachers. The issues from 1990-1996 were examined by the author with permission in October, 1997. In this period, 54 teachers were disciplined for sexual misconduct with children. For female teachers, four were disciplined: three were same-sex incidents, and for one the gender of the victim was not identified. For male teachers, 33 were heterosexual offenses, 13 were homosexual, and four were not identified. Thus, out of a total of 49 cases where the gender of the victim was identified, 16 were homosexual (33%), which is approximately 15 times their incidence in the population, using incidence data from Laumann *et al* (1994).

This data is further supported by two studies of adult sex offenders conducted by Kurt Freund, a psychiatrist at the Department of Behavioral Sexology at the Clarke Institute of Psychiatry in Toronto (Freund *et al*, 1984; Freund & Watson, Spring, 1992). In the 1984 study (which examined only males), Freund found that the pedophilic predilection is more likely to be found in those of homosexual orientation and that they had the highest rate of recidivism. A related study (Abel *et al*, 1987) determined that the self reported number of male victims of non-incarcerated male pedophiles averaged an astonishing 150.2 (the corresponding rate for heterosexual pedophiles was 19.8).

In his second study, Freund examined the offense records of 457 sex offenders and found that the proportional prevalence of homosexual offenders was 36% (Freund & Watson, 1992). Other researchers have noted that 23% of gay men and 6% of lesbians admitted to sexual interaction with youth under the age of 16, when the respondent was aged 20 or older (Jay & Young, 1979). The preponderance of evidence clearly indicates that persons

of homosexual orientation are much more susceptible to pedophilic tendencies.

Paternal Deprivation/Parental Mental Health in Transgenderism

Other researchers have zeroed in on the role parental deprivation plays in the sex role learning process. George Rekers, a recognized expert in gender identity disorder who has authored or co-authored over 60 studies on the question, writes "The impact of paternal deprivation on psychosexual development is most conspicuous in the retrospective clinical studies of homosexual and transsexual men (Rekers, 1996). The most seriously gender disordered boys had 100% paternal deprivation. Rekers also noted that 80% of the mothers and 45% of the fathers of his study group had a history of mental health problems or psychiatric treatment (Bentler, Rekers & Rosen, 1979). It is generally accepted that approximately 80% of children diagnosed with gender identity disorder later identify as homosexual in adulthood (Nicolosi & Nicolosi, 2002). Sexual identity is a tremendously complex interaction of psychosocial forces, and is particularly influenced by the absence of a paternal figure, the mental health of the parents, especially the mother, childhood sexual experiences, and non-conforming gender behaviour.

Sexual Preference Reversal Therapy

Can someone who thinks they are homosexual change their orientation to heterosexuality? The answer is clearly yes, but many gay support groups have lobbied hard to have the American Psychological Association make it unethical for psychologists to assist gays with conversion therapy, even if they asked for it (Satinover, 1996b). They assert that reparative or conversion therapy is ineffective at best, and harmful at worst (Forstein, 2001). This position has been vigorously opposed by the National Association for the Research and Therapy of Homosexuality, headed by clinical psychologist Dr. Joseph Nicolosi. The situation came to a head at the APA's annual convention in Chicago in 1995 (Sleek, October, 1997).

The APA's Council of Representatives, after carefully weighing all the evidence presented by both sides of the issue, determined that there was no evidence that conversion therapy was harmful, and that making the ethical change requested by "gay affirming" lobbyists would constitute an unwarranted intrusion into the client-therapist relationship, and could be

construed as "restraint of trade" (Sleek, October, 1997). The Council reaffirmed, however, the APA's position that a homosexual or bisexual orientation alone did not constitute a mental illness or a requirement for treatment. The APA has even published reparative therapy research in their own journal (Throckmorton, 2002).

The current position of the American Psychiatric Association is that it "encourages and supports research to further determine 'reparative' therapy's risks versus its benefits" (American Psychiatric Association, 2000). In his own investigation, Robert Spitzer, the psychiatrist who orchestrated the removal of homosexuality from the *DSM* in 1973, found that "…there was no evidence of harm. To the contrary, they reported that it was helpful in a variety of ways beyond changing sexual orientation" (Spitzer, October, 2003).

Those who are experiencing unwanted same-sex attraction and have sought therapy to convert to heterosexual functioning have had considerable success with existing therapeutic methods. Behavioral therapy has been found to have permanent sex identity reversal success rates of between 65% after a five year follow-up (Schwartz & Masters, 1984), and 71% after a six year follow-up (Masters & Johnson, 1979). Even Kinsey reported more than 80 cases of successful "revision therapy" (Pomeroy, 1972).

Dr. Jeffrey Satinover notes that in an eight year period (1966-1974), over 1000 articles on the treatment of homosexuality were listed in the Medline database. Moreover, a representative cross-section of these treatment modalities recorded an average success rate of 52% (Satinover, 1996b). Dr Judd Marmor, past president of the American Psychiatric Association and the American Academy of Psychoanalysis, reports that "between 20 and 50 per cent of patients with homosexual behavior seek psychotherapy in order to change their orientation…and they deserve the help of psychiatry to achieve it" (Marmor, 1975).

There is considerable evidence that people can experience orientation change even without treatment. Kinsey Institute researchers Bell and Weinberg found that 84% of homosexuals and 29% of heterosexuals shifted their orientation at least once in their lifetime, and 32% of homosexuals and 4% of heterosexuals reported a second shift in orientation. A significant 13% of homosexuals and 1% of heterosexuals claimed at least five orientation changes in their lifetimes (Bell & Weinberg, 1978). Thus, the

claims that orientation is ingrained at birth and immutable throughout a person's lifetime does not seem to have the support of empirical data.

Homosexuality and Social Politics

Until 1973, the American Psychiatric Association labeled homosexuality as a psychological disorder. It was dropped from the *DSM*, not because of a preponderance of new research and scholarly debate, but because of intense political lobbying from the homosexual community (Bayer, 1981). Apparently, they threatened to continue demonstrating at every APA convention and block research until it was dropped from the manual (Zustiak, February 14, 1993).

Joseph Berger, a Canadian psychiatrist who was at the 1973 convention reported that the APA was bombarded with letters petitioning for the removal of homosexuality from the manual, ostensibly from concerned individuals. The campaign was later found to have been orchestrated and financed by gay activist groups (Berger in Social Action Commission, 1993).

Charles Socarides, past president of NARTH, wrote that psychiatrists who continued to believe that homosexuality was a disorder, were "soon silenced at our own professional meetings, our lectures were cancelled inside academe, and our research papers were turned down in the learned journals" (Socarides, 1996). This says more about the effectiveness of the gay lobby than a change in professional thinking.

The effectiveness of the gay lobby may have been enhanced by high level influence from within the APA Board of Trustees. A former gay man told psychiatrist Jeffrey Satinover at a 1994 conference in England, that he and his lover celebrated the 1973 victory in the apartment of an officer of the APA Board of Trustees. Satinover regards this as evidence that the leadership of the APA could have been suborned in this decision (Satinover, 1996b).

Significantly, four years after homosexuality was relabeled from a disorder to a "condition", akin to handedness, a National Institute of Mental Health survey of 2500 psychiatrists found that 69% of them still believed that homosexuality "usually represents a pathological adaptation" while only 18% were sure it did not (in Bayer, 1981). Moreover, in 1980, the American

Psychiatric Association affirmed a new form of psychopathology after considerable research, entitling it Gender Identity Disorder, with subcategories for children, adolescents, and adults (Rekers, 1996).

The *DSM-IV* (APA, 1994), also contains diagnostic categories for transvestitism and category 302.9(3) "persistent and marked distress about one's sexual orientation", often used for applying a diagnostic label to unwanted same-sex attraction. Indeed, gay adolescents in British Columbia rated "worries about my sexual orientation" as the third most common reason for a suicide attempt (McCreary Centre Society, 1999). Clearly, if anxiety about orientation is causing distress and dysfunction, and the desire of the client is to overcome unwanted same sex attractions, it is only ethical to offer appropriate therapeutic assistance, or refer the client to a qualified reparative therapist who will.

Writes Christopher Rosik, Ph.D.: "Assuming clients are provided with informed consent in a non-coercive environment, the recognition that some individuals with homoerotic attraction will still want to pursue change-oriented therapy upholds the ethical assumption that clients make autonomous choices that [marriage and family therapists] must respect. In addition, because many of these clients are motivated to attempt change because of deeply held religious convictions, allowing them to pursue such therapy supports the AAMFT ethical pledge not to discriminate on the basis of religion, respecting religious diversity even when members may hold different moral beliefs regarding homosexual behavior and sexual identity" (Rosik, January, 2003).

Conclusions and Recommendations

It is apparent from the data cited in this paper that it would be highly inappropriate for public school educators to provide instruction that implies there is no qualitative difference between the orientations in terms of physical and mental health risks, suicide risks, STD infection, or longevity. Parents and educators need to be aware that the research evidence that homosexuality is innate and immutable has not been validated, and may be employed in a manipulative fashion.

Reparative therapy for adults with unwanted same sex attraction has been shown to be effective and accrue positive benefits in other areas of life. To accept the notion that nothing can be done to change sexual identity,

especially prior to self initiated sexual activity, would be professionally irresponsible. Parents ought to be aware that there are treatment options, and recognized diagnostic categories. Moreover, given the much high incidence of childhood abuse among homosexuals, and the astounding rate of victimization of boys at the hands of homosexual pedophiles, counselors should be alert to undisclosed and untreated sexual abuse among students presenting with issues related to orientation.

The data cited in this paper has shown that the homosexual lifestyle is characterized by high levels of relationship instability, promiscuity, high risk of acquisition of deadly STD's and mental illnesses, suicidality, substance abuse, and shortened longevity. It is clear that this issue requires much more dedicated research before wholesale implementation of anti-homophobia and heterosexism programs in the public school system to "normalize" homosexuality. The clinical and empirical data alone, notwithstanding the substantial question of moral and religious beliefs, require that the teaching profession approach this issue with considerable caution.

Nevertheless, programs to reduce harassment of students of alternate sexual orientations, if developed with sensitivity to the religious traditions present among students, teachers, and parents in the public school system, will be beneficial and should be implemented as soon as possible.

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