Gay Teens and the American Medical Association:

Why AMA Policy is Not in the Best Interest of Children or Families

By Dale O'Leary

(Adapted from an article in the online newsletter, HEARTBEAT NEWS #20, June 21, 2001)

Dale O'Leary

Last June, the American Medical Association voted into official policy a resolution that says it is a health risk to ban homosexuals from youth organizations such as the Boy Scouts because "discriminatory policies increase the risk of suicide and depression among gay-oriented youth."

It is true that boys who self-identify as gay are at high risk for a number of problems including suicidal ideation and depression. But if discrimination is defined as believing that homosexual acts are contrary to a moral law and homosexuality is not equal to heterosexuality, then there is no question that significant "discrimination" exists within society.

The vast majority of parents do not want their children to become homosexual. In fact, research suggests that a significant percentage of homosexuals themselves do not believe homosexuality is as desirable as heterosexuality. (Shidlo 1994)

Unfortunately, the AMA appears to have accepted the unsubstantiated claim that the numerous psychological problems and self-destructive behavior found among persons who self-identify as gay, lesbian, or bisexual (GLB) are caused by social discrimination. It has ignored substantial evidence suggesting that the negative outcomes are related to the homosexuality itself.

High-Risk Lifestyles

Is it true that gay and lesbian-identified teenagers are just like straight teens—except for the problem of society's discrimination?

Garofalo et al (1998) documents the lifestyle factors associated with GLB adolescents in a a study of 4,159 students from 9th to 12th grade students in Massachusetts, of which 104 (2.5%) self-identified as GLB.

The GLB students were more likely than non-GLB students to have engaged in 30 different high health risk behaviors, including the following:

	GLB	vs. non-GLB
Alcohol use (<age 13)	59.1%	30.4%
Cocaine use (<age 13)	17.3%	1.2%
Inhalant use (life)	47.6%	18.5%
Ever had sexual intercourse	81.7%	44.1%
Three or more sexual partners (life)	55.4%	19.2%
Alcohol or drug use at last sexual episode	34.7%	13.3%
Sexual contact against will	32.5%	9.1%

As for promiscuity, according to the study, "students with six or more sexual partners in their life were 7.62 times more likely to be classified as GLB than were students who had never had sexual intercourse." And the greater the number of lifetime sexual partners, the greater the risk of contracting an STD.

The authors clarify that their sample is not an aberrant group of "street" kids—all were in school. The study found that GLB youth that self-identify during high school are more likely, before age 13, to initiate sexual intercourse and engage in cocaine, marijuana, and tobacco use.

The authors concluded that:

> GLB youth who self-identify during high school report disproportionate risk for a variety of health risk and problem behaviors, including suicide, victimization, sexual risk behaviors, and multiple substance use. In addition, these youth are more likely to report engaging in multiple risk behaviors and initiating risk behaviors at an earlier age than their peers.

The authors simply assume the politically correct perspective: that these teenagers' high-risk lifestyles are attribut-

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able to social stigma—but they present no evidence to prove that this is in fact the case. They recommend educational programs, but present no evidence that such programs will actually prevent the problems cited.

Potentially Fatal Risk: HIV/AIDS

It is clear from the Garofalo study that boys who self- identify as gay are engaging in behaviors that put them at high risk for contracting HIV, and the latest testing reveals that these risks are in fact being realized. According to the Centers for Disease Control (MMWR 2001) study, among men who have sex with men (MSM):

5.6% aged 15 to 19 years are HIV positive
8.6% aged 20 to 22 years are HIV positive
13% aged 23 to 29 years are HIV positive.

Those educators who encourage boys to self-identify as gay at an early age argue that "coming out" will raise the boy's self-esteem, allow him to receive safer sex (condom) education, and, therefore protect him from HIV infection. However, the figures show that, in spite of all the condom education and support for "coming out," among young MSM the percentage infected with HIV is actually increasing. When an adolescent boy begins to have sex with men, he is much more likely to take risks and become infected than is a man in his later 20s and 30s.

Psychiatric Problems

The AMA blames gay teens' suicidal feelings and depression on the Boy Scout policy and other familial and institutional forms of social discrimination. However, three new, well-designed studies cast doubt on that all-too-facile assumption. These studies reveal that psychiatric problems, including suicidal ideation and depression, are common among homosexual adults as well—not only in the United States, but also in New Zealand, and most significantly, in The Netherlands.

The Netherlands is noted for its broad and far-reaching tolerance of many forms of sexual deviation (including prostitution, which is legal; they are also known for a tolerance of pedophilia). Sandfort et al. (2001) compared lifetime prevalence of DSM-III-R Psychiatric Disorders in homosexual and heterosexual men in that country. The study found significant differences, as follows:

Lifetime prevalence of DSM-III-R Disorders

	Homosexual	Heterosexual
Mood disorders	39.0%	13.3%
Major depression	29.3%	10.9%
Anxiety disorders	31.7%	13.2%
One or more diagnoses	56.1%	41.4%
Two or more	37.8%	14.4%

Another study by Fergusson *et al.* of a birth cohort in New Zealand also found significant differences between GLB and non-GLB youth. The persons in this study were chosen at birth and followed to age 21. (This kind of study eliminates sampling bias.) At age 21, 2.8% of the cohort self-identified as GLB. When they were compared to the non-GLB group there were significant differences, as follows:

	GLB	Non-GLB
a) Suicidal ideation	67.9% -	28.0%
b) Suicide attempt	32.1%	7.1%
c) 2 or more psychiatric disorders, ages 14-21	78.6%	38.2%

Herrell *et al.* studied twins in a group of male Americans who were part of a larger study and found that those who had had sex with a man were significantly more likely to have attempted suicide. The percentage of twins who actually had attempted suicide are as follows:

a) Twins who were both heterosexual	2.2%
b) Heterosexual twin with homosexual co-twin	3.9%
c) Homosexual twin with heterosexual co-twin	14.7%
d) Twins both homosexual	18.8%

Suicide Risks

According to Gary Remafedi (1999), six studies of homosexual youth compared attemptors and nonattempters. They found that suicide attempts were significantly more common among gender-nonconforming (effeminate) males, those who had an early awareness of homosexuality, those with family problems, and those who abused drugs or had other psychiatric problems.

In one of the studies referenced, Remafedi et al (1991) studied 137 gay and bisexual males aged 14 to 21. Of that group, 41 reported a suicide attempt, and almost half of the attempters reported multiple attempts. According to the article:

> "Compared with non-attemptors, attemptors had more feminine gender roles and adopted a bisexual or homosexual identity at younger ages. Attemptors were more likely than peers to report sexual abuse, drug abuse, and arrest for misconduct."

Here are a few of the key differences. **Notice that gender-identity problems are a key indicator;** also, note that the gay *non*-attempters are themselves, hardly problem-free:

	Suicide Attempters	Non-Attempters
a) Sexual abuse	61%	29%
b) Prostitution	29%	17%
c) Illicit drug use	85%	63%
d) Classification: masculine	**7%**	**26%**

The differences between the attemptors and non-attempters in the Remafedi study suggest that suicide attempts are related to specific problems — namely, **untreated Gender Identity Disorder** (GID) and also with **unidentified and untreated trauma associated with sexual abuse.** Adolescent prostitution is frequently a sign of previous childhood sexual abuse. Drug and alcohol use, suicide, and depression have also been linked to a history of childhood sexual abuse.

Real Solutions

The studies cited here represent only a small portion of the research on this subject. When the studies are taken as a whole, it is clear that a boy who self-identifies as "gay" is at high risk— first for infection with HIV or another STD, second for psychiatric problems including suicidal ideation, and third for self-destructive behaviors including drug and alcohol abuse and prostitution.

The AMA has presented no evidence that admission of a boy who self-identifies as gay into the Boy Scouts would in any way ameliorate the underlying problems associated with homosexuality.

Still, there is action which can be taken.

1) Aggressive diagnosis and treatment of boys with GID. These boys are at higher risk for almost every negative outcome. GID is easy to recognize; the child's parents know, the neighbors know, the teachers know, and the pediatricians know that these boys have a problem.

Rather than blaming the Boy Scout policy for causing the problem, the American Medical Association can advise pediatricians to recommend treatment, because treatment —particularly when begun early—can be successful in eliminating the symptoms (Zucker 1995). Still, many parents report that even when they specifically express concern to their pediatrician, they are told not to worry—the boy will get over it. But this optimism is not borne out by the research, which suggests that boys with childhood GID are at high risk for a number of negative outcomes in adolescence and adulthood.

For example, boys with GID are extremely likely to be victimized by bullies and targeted by pedophiles. It has been estimated that without intervention, 75% will become sexually attracted to males and engage in same-sex behavior. Given the high rate of HIV among MSM, the parents' concerns are therefore fully justified. While there is no guarantee that treatment will prevent same-sex attraction in adolescence, it can alleviate the problems associated with GID in childhood. These are troubled children who need help.

Why has the AMA not promoted aggressive treatment of GID in boys when the negative consequences are so well-documented?

2) The A.M.A. can alert health-care professionals and educators to the link between sexual child abuse and various negative outcomes.

Gay activists have mounted a worldwide campaign aimed at encouraging adolescent boys experiencing confusion about their sexual attraction pattern to "come out." Many of these boys have been victims of sexualized child abuse. Boys may think they are homosexual because they were targeted by a male pedophile, or because in spite of the humiliation, they also experienced pleasurable sensations during the abuse. Therapy directed at addressing this trauma could be beneficial.

While some adolescents may initially feel better when they "come out" because they feel accepted, the negative outcomes associated with homosexuality will not be resolved by such a declaration. Drug and alcohol abuse, unsafe sexual practices, and psychological problems are epidemic among MSM. The younger a boy is when he begins to have sex with men, the greater the risk.

Options

What are the options when a teenager experiences same-sex attractions—but he also wants to be a Boy Scout?

1) He could choose to self-identify as "gay," but in doing so, he will identify with a community whose values and interests are antithetical to those of the Boy Scouts. The gay community aggressively promotes sexual liberation without guilt or restrictions. Their attitudes toward lowering the age of consent, prostitution, and extreme sexual behaviors are well-documented. Drug and alcohol abuse is also widespread in this community. This choice between these two worlds is a serious one, and no boy should be rushed into making it.

2) Or the boy could postpone self-identification as gay, not act on his attractions, continue his membership in the Boy Scouts, and hope that the attractions will diminish or disappear. In time they may; but even if they do not, and at a later stage he does choose to identify as "gay," postponing self-identification will still have lowered his personal risk for contracting HIV and other negative outcomes.

3) The boy can seek help for these attractions. Counseling

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should be directed toward helping him identify and deal with the childhood conflicts and traumas. The Boy Scouts is not equipped to provide this kind of therapy, and unfor-tunately, therapy of this kind for adolescents is not uni-versally available. But if the attractions abate and he does not identify himself as gay, he can still be a part of the Boy Scouts.

Blame

If blame for the problems associated with homosexuality among adolescent males is being handed out, the AMA deserves a share.

By failing to encourage aggressive treatment of gender-identity disorder and by failing to alert professionals to the link between sexual child abuse, homosexuality, and suicide, it is the A.M.A. who puts these children at risk. When the A.M.A. endorses the unsubstantiated claim that discrimination is the sole cause of problems associated with homosexuality— *and when they shift the blame to the Boy Scouts*—their culpability is compounded.

Given that the age at which a male homosexual begins to have sex with men directly correlates with his risk for HIV infection, physicians should be doing everything possible to prevent infection by preventing same-sex behavior among adolescents-—or at the very least, delaying it as long as possible.

"Give us your children," they say, "and we will make their lives safer and happier." The result is predictable: education doesn't solve the problem. In fact, the problem increases. Activists then call for *more* money, *more* power, *more* programs, *more* education. And the media has utterly failed to challenge this misguided strategy, or or to hold the A.M.A. accountable. ■

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