III. Response to APA Claim: There Is No Greater Pathology in the Homosexual Population Than in the General Population

There is a general consensus in the scientific literature that greater pathology exists among homosexually-oriented people than among heterosexuals. In fact, it is difficult to find another group in society with such high risks for experiencing such a wide range of medical, psychological, and relational dysfunctions.

Recent research using methodologically current quantitative survey criteria confirms the results of less rigorous studies from several decades ago. The pathology is not of a single kind; rather, it has many individual manifestations. It consists of a strikingly greater incidence of a wide range of mental health disorders—specifically substance abuse, depression, and suicidality; but also extending to pathological risk-taking, high breakup rates of relationships, and sexual addiction. No empirical study has ever documented that these higher rates of pathology may be explained solely (or even primarily) by society's disapproval of homosexuality.

Higher Levels of Mental Health Problems

Preeminent reports on the question of the relationship between homosexuality and psychopathology among both young people and adults were written by Herrell et al. (1999) and Fergusson, Horwood, and Beautrais (1999), and were published in the *Archives of General Psychiatry*. In his commentary on these meta-analytic studies, Bailey (1999) concludes:

> 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 forms of emotional problems, including suicidality, major depression, and anxiety disorder. (p. 883)

The findings of Herrell et al. (1999) and Fergusson et al. (1999) are summarized as follows:

- Reports of lifetime measures of suicidality are strongly associated with a same-gender sexual orientation (Herrell et al., p. 873).
- The substantially increased lifetime risk of suicidal behaviors in homosexual men is unlikely to be due solely to substance abuse or other psychiatric comorbidity (p. 867).

- Findings support recent evidence suggesting that homosexual and bisexual young people are at increased risk of mental health problems, with these associations being particularly evident for measures of suicidal behavior and multiple disorders (Fergusson et al., 1999, p. 876).
- Emerging consensus from recent studies is that young people who disclose homosexual behaviors or attraction are at increased risk of suicidal behaviors and mental health problems (p. 880).
- Homosexual and bisexual young people are at increased risk of major depression, generalized anxiety disorder, conduct disorder, nicotine dependence, other substance abuse and/or dependence, multiple disorders, suicidal ideation, and suicide attempts (p. 876).

One should ask whether the results of these studies may be unique to a country and culture that is considered intolerant of homosexual behavior, such as the United States. To the contrary, Bailey (1999) concludes that "results from a large, equally as well-conducted Dutch study [Sandfort, de Graaf, Bijl, & Schnabel, 1999] generally corroborate these findings" (p. 883). The Dutch society is well-known for its great tolerance and acceptance of homosexuals (Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Bailey (1999) opines further that possible reasons for the higher level of mental health problems in the homosexual population include not only the usual hypothesis about social discrimination, but also the following:

> Homosexuality represents a deviation from normal development and is associated with other such deviations that may lead to mental illness.
>
> Increased psychopathology among homosexual people is a consequence of lifestyle differences associated with sexual orientation, . . . such as behavioral risk factors associated with male homosexuality, . . . [including] receptive anal sex and promiscuity. (p. 884)

Bailey concludes, "It would be a shame if sociopolitical concerns prevented researchers from conscientious consideration of any reasonable hypothesis" (p.884).

Gilman et al. (2001) studied a random, nationally representative household survey of the general U.S. population. The sample consisted of 125 men and women reporting any homosexual behavior in the past five years and 4,785 men and women reporting exclusively opposite-sex sexual partners. The participation rate was 82.4 percent. These researchers found the following *12-month prevalences* (P) and *lifetime risk or odds ratios* (LOR) of homosexual (same sex-attracted or SSA) *women* to heterosexual (opposite sex-attracted or OSA) *women* for the following disorders:

- *Post-Traumatic Stress Disorder*—P: 20.9% SSA vs. 5.9% OSA; LOR = 2.7 (SSA > OSA).
- *Anxiety Disorder*—P: 40% SSA vs. 22.4% OSA; LOR = 1.8 (SSA > OSA).
- *Major Depression*—P: 34.5% SSA vs. 12.9% OSA; LOR = 1.9 (SSA > OSA).
- *Thoughts of Suicide*—LOR = 2.0 (SSA > OSA).
- *Any Mood Disorder*—P: 35.1% SSA vs. 13.9% OSA; LOR = 2.0 (SSA > OSA).
- *Any Substance Use Disorder*—P: 19.5% SSA vs. 7.2% OSA; LOR = 2.4 (SSA > OSA).

Among *men*, these researchers found the following *lifetime risk or odds ratios* (LOR) comparing homosexual (SSA) with heterosexual (OSA) *men*:

- *Drug Abuse Disorder*—LOR = 2.8 (SSA > OSA).
- *Drug Dependence Disorder*—LOR = 2.4 (SSA > OSA).
- *Thoughts of Suicide*—LOR = 2.2 (SSA > OSA).

Similarly, Jorm, Korten, Rodgers, Jacomb, and Christensen (2002) conducted a random, nationally representative household survey of the general Australia population. The participation rate was 58.6 percent, and the sample consisted of 149 men and women identifying themselves as homosexual or bisexual and 4,675 men and women identifying themselves as heterosexual. The homosexual and bisexual groups reported significantly poorer mental health in terms of anxiety, depression, suicidality, and negative affect than the heterosexual group.

Research from a different country also documents that homosexuals have a lower overall quality of life compared to heterosexuals. Sandfort, de Graaf, and Bijl (2003) studied a random, nationally representative household survey of the general population in the Netherlands. The sample consisted of 125 men and women reporting homosexual behavior and 5,873 men and women reporting only heterosexual behavior, and the participation rate was 69.7 percent. Homosexual men were found to have a significantly lower quality of life compared to heterosexual men in terms of general health, mental health, emotional role functioning, social functioning, and vitality. Sandfort et al. (2003) concluded:

> Compared to heterosexual men, homosexual men evaluated their general level of health and their mental health as less positive, reported that emotional problems more often interfered with work or other daily activities, that physical health or emotional problems interfered with normal social activities, and felt less energetic. (p. 18)

Conron, Mimiaga, and Landers (2008) conducted a population-based telephone survey of Massachusetts adults for the Massachusetts Department of Public Health (MDPH). From 2001 to 2006, 38,910 adult residents of Massachusetts were administered the Behavioral Risk Factor Surveillance System, which is a collaborative effort between the U.S. Centers for Disease Control and Prevention (CDC) and state departments of public health. The MDPH added questions to assess differences in self-reported adult health behavior and status by sexual orientation for adults ages 18–64. During the years surveyed, most (97.1 percent) participants self-identified as straight or heterosexual, while 1.9 percent identified as gay, lesbian, or homosexual, and 1 percent as bisexual. The authors reported comparisons of health behavior and status between straight/heterosexual and gay/lesbian/homosexual residents and between straight/heterosexual and bisexual residents separately.

Gay/lesbian/homosexual residents reported having a poorer health profile than straight/heterosexual residents on:

- Self-reported health as fair/poor (odds ratio [OR] 1.45)
- Physical, mental, or emotional disability-related activity limitation (OR 1.78)
- Asthma (OR 1.51)
- Current (OR 2.47) and past tobacco smoking (OR 1.67)
- Anxious mood; feeling tense or worried for more than 14 of the last 30 days (OR 1.4)
- Binge drinking in the last 30 days (OR 1.29*)
- Illicit drug use in the last 30 days (OR 2.98)
- Lifetime having ever been sexually assaulted (OR 2.91)

** Statistically significant but potentially unstable estimate due to high relative standard error.*

Bisexual residents reported having a *poorer* health profile than heterosexual/straight residents on:

- Self-reported health (OR 4.44)
- Anxious (OR 3.10) and depressed (feeling sad or blue for more than 14 of the last 30 days) moods (OR 2.6)
- Suicide ideation in the prior 12 months (OR 9.16)
- Current tobacco smoking (OR 2.96, women; OR 2.10, men*)
- Having ever been sexually assaulted (3.68), in the prior 12 months (OR 4.02*)

** Statistically significant but potentially unstable estimate due to high relative standard error.*

In addition, compared with heterosexual/straight women, *bisexual women* were more likely to report:

- Disability-related activity limitation (OR 5.26)
- Illicit drug use in the last 30 days (OR 8.8)
- Lifetime threat of or actual physical assault by intimate partner (OR 7.98*)

** Statistically significant but potentially unstable estimate due to high relative standard error.*

No significant differences were found when comparing the reported incidence of these three health issues between bisexual and heterosexual *men*.

Other sex differences were found concerning weight. While lesbian/homosexual *women* were *more* likely to be *obese* (OR 2.23) than heterosexual/straight women, gay/homosexual *men* were *less* likely to be *obese* (OR 0.42) or *overweight* (OR 0.57) than were straight/heterosexual men. No differences were found when comparing the weight of straight/heterosexuals and bisexuals of either sex. Also, bisexual *women* were more likely than straight/heterosexual women to report illicit drug use (OR 8.80), while no statistically significant difference was found between the incidence of substance use by bisexual and straight/heterosexual men.

Overall, gay/lesbian/homosexual adults reported poorer health and greater risks than straight/heterosexuals across several health domains, and bisexual adults reported even more. The researchers reported no statistical comparisons of health behavior and status between gay/lesbian/homosexual and bisexual residents. Further analysis and additional research would help explain any clinical significance about what led bisexual (but *not* gay/lesbian/homosexual) residents of Massachusetts to experience more *depressed mood*, *heart disease*, *suicidal ideation*, and *sexual assault in the prior 12 months*, and less *health insurance* and access to a *regular health care provider* and *dental care* than heterosexual men; and gay/homosexual (but *not* bisexual) men to have had statistically greater odds of c*olorectal cancer screening* (sigmoidoscopy/colonoscopy), *condom use*, *asthma, binge drinking*, having been a *former (vs. never) smoker,* and *disability-related activity limitation* than heterosexual men.

A recent meta-analysis supports the general results of the studies reported above. King et al. (2008) located 13,706 scholarly publications between 1966 and April 2005 on the prevalence of mental disorder, substance misuse, suicide, and deliberate self-harm among homosexuals. Of those publications, 28 met at least one or more of four methodological quality criteria for inclusion in a meta-analysis: random sampling, 60 percent or greater participation rate, sampling from the general population instead of a selected group, and sample size equal to or greater than 100 research subjects. A comprehensive systematic meta-analysis of these 28 highest-quality studies, reporting research on a combined 214,344 heterosexual and 11,971 homosexual subjects, found the following:

Risk Comparisons for Men

- Homosexual men demonstrated 2.58 times increased risk of lifetime prevalence of depression compared to heterosexuals (p. 77).
- Homosexual men demonstrated 4.28 times increased risk of lifetime prevalence of suicidal attempts compared to heterosexuals (p. 74).
- Homosexual men demonstrated 2.30 times increased risk of lifetime prevalence of deliberate self-harm compared to heterosexuals (p. 75).
- Homosexual men demonstrated 1.88 times increased risk of 12-month prevalence of anxiety disorders compared to heterosexuals (p. 78).
- Homosexual men demonstrated 2.41 times increased risk of 12-month prevalence of drug dependence compared to heterosexuals (p. 80).

Risk Comparisons for Women

- Homosexual women demonstrated 2.05 times increased risk of lifetime prevalence of depression compared to heterosexuals (p. 77).
- Homosexual women demonstrated 1.82 times increased risk of lifetime prevalence of suicidal attempts compared to heterosexuals (p. 74).
- Homosexual women demonstrated 4.00 times increased risk of 12-month prevalence of alcohol dependence compared to heterosexuals (p. 79).
- Homosexual women demonstrated 3.50 times increased risk of 12-month prevalence of drug dependence compared to heterosexuals (p. 80).
- Homosexual women demonstrated 3.42 times increased risk of 12-month prevalence of any substance use disorder compared to heterosexuals (p. 81).

The results of this meta-analytic study by King et al. (2008)—as well as those reported above from Herrell et al. (1999), Fergusson et al. (1999), Gilman et al. (2001), Jorm et al. (2002), Sandfort et al. (2003), and Conron et al. (2008)—offer clear evidence that people who are homosexually-oriented are at significantly greater risk for experiencing serious medical and mental health problems than are heterosexually-oriented persons.

Discussion of Specific Areas of Medical and Mental Health Risk

Substance Abuse

Alcohol

Homosexual men in the United States report being afflicted with drug and alcohol dependencies at rates that are much higher than that of the general population. Studies since 1975 show that these rates are as high as double those of the heterosexual population (Craig, 1987; Fenwick & Pillard, 1978; Fifield, 1975; Fifield, Latham, & Phillips, 1977; Gruskin & Gordon, 2006; Hatzenbuehler, Corbin, & Fromme, 2008; Lewis, Saghir, & Robins, 1982; Lohrenz, Donnelly, Coyne, & Spare, 1978; Meissner & Morton, 1977; Saghir & Robins, 1973; Sandfort et al., 2001; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; Saunders, 1984; Skinner, 1994; Weinberg & Williams, 1975; Ziebold, 1979). A few researchers have reported lower prevalences; Stall and Wiley (1988) reported only 19 percent higher, and Smith (1979) reported rates among homosexuals as being only 10 percent higher.

In the Stall et al. (2001) study of a household-based probability telephone sample of 2,172 urban men who had sex with men in the previous five years in selected zip codes of Chicago, Los Angeles, New York, and San Francisco, 85 percent of homosexually behaving men reported alcohol use. Researchers report that binge drinking among homosexuals occurs more frequently than in society at large (Ostrow, 1990; Ostrow, Beltran, & Joseph, 1994).

Similar findings exist for homosexual women, whose alcohol consumption is on average three times that of heterosexual women (Anderson & Henderson, 1985; Burke, 1982; Diamond & Wilsnack, 1978; Hughes & Wilsnack, 1994; Johnson & Palermo, 1992; King & Nazareth, 2006; Meads, Buckley, & Sanderson, 2007; Nardi, 1982; Sandfort et al., 2001, 2006; Valanis et al., 2000; Weathers, 1980; Wilsnack et al., 2008; Ziebold & Mongeon, 1982).

Cochran, Keenan, Schober, and Mays (2000) reported a nationally representative household survey of the general U.S. population in which the participation rate was 79 percent. The sample consisted of 194 men and women reporting at least one same-gender sexual partner in the past year, and 2,844 men and women reporting only opposite-gender sexual partners. Cochran et al. found:

> Homosexually active women reported using alcohol more frequently and in greater amounts and experienced greater alcohol-related morbidity than exclusively heterosexually active women. Findings suggest higher risk for alcohol-related problems among lesbians as compared with other women. (p. 1062)

Cochran et al. reported the following comparisons:

- 30.3 percent of homosexually active women were "very high or drunk 3 or more days" in the past year compared to 16.6 percent of heterosexual women (p. 1066).
- 8.4 percent of homosexually active women were "very high or drunk an average of once per week or more" in the past year compared to 2.3 percent of heterosexual women (p. 1066).
- 7 percent of homosexually active women reported heavy drinking in the past month compared to 2.7 percent of heterosexual women (p. 1066).

Drabble and Trocki (2005) reported a nationally representative household telephone interview survey of the general U.S. population. This female sample consisted of 36 who identified themselves as lesbian, 71 who reported themselves as heterosexual and having had same-sex partners, 50 who reported themselves as bisexual, and 3,723 who reported themselves as heterosexual. Overall, 41.8 percent of lesbians and 45.6 percent of bisexuals reported they were heavy alcohol drinkers, compared with 12.7 percent of heterosexuals. Alcoholism among homosexual women is evidently so problematic that even with a support system such as Alcoholics Anonymous (AA), they do not respond as well to counseling as their heterosexual counterparts (Hall, 1994).

The message that homosexuals were heavier drinkers was so clear in the 20th century that it inspired advertising strategies. For example, Earl Nissen of the Coors Brewing Company told *Advertising Age* that homosexual men drank twice as much as heterosexual men, so they developed ads that would appeal more to homosexuals in order to yield more sales for the company (Pruzan, 1996).

Leukefeld, Battjes, and Armsel (1990) and Wang, Häusermann, Ajdacic-Gross, Aggleton, and Weiss (2007) report that homosexual youth have an unusually high prevalence of alcoholism when compared with heterosexual youth. A meta-analysis combining the data of 18 studies concluded that the risk of alcohol abuse among homosexual youth is 3.4 times that for heterosexual teens (Marshal et al., 2008).

Bisexuals have been shown to have varying rates of alcoholism, and the specific rates vary depending on the study. Regardless, the incidence of alcoholism among bisexuals is generally higher than that among heterosexuals (Bostwick et al., 2007; Jorm et al., 2002; King & Nazareth, 2006; Wilsnack et al., 2008).

Drug Use

A representative study of the U.S. population that compared the rates of illicit drug use among homosexuals to the National Household Survey on Drug Abuse found that homosexuals had a higher rate of such use than heterosexuals (Skinner, 1994).

An earlier longitudinal study in Boston conducted between 1985 and 1988 on a convenience sample of more than 400 homosexuals found that 80 percent used marijuana, 70 percent used amyl nitrate (also known as "poppers"), 60 percent used cocaine, 30 percent used amphetamines, and 20 percent used LSD. No control group of comparable heterosexuals was studied (Seage, 1992). In another convenience sample of 1,000 homosexual men who were not compared with a control group of heterosexuals, the use of drugs—such as marijuana, cocaine, and amyl nitrite—was widely reported, as was binge drinking (Ostrow et al., 1994).

Amyl nitrite is used for its euphoric effects, but also because it relaxes the anal muscles. Fifty-seven percent of 150 homosexual men interviewed admitted to using amyl nitrite at least once in the six months prior to the interview (Goode & Troiden, 1979). In another study, 86 percent of 250 homosexual men had inhaled amyl nitrite within the last five years—a proportion similar to the 86.4 percent reported in STD clinics in Atlanta, New York, and San Francisco (McManus, Starrett, & Harris, 1982). That level of usage is not common among heterosexuals (Newmeyer, 1992).

Among homosexual men, there is heavy use of both injected and noninjected drugs, with 17 percent reporting the use of intravenous drugs (Lauritsen, 1993). In most studies, substance abuse is higher among homosexual than heterosexual men, and even higher among homosexual women than among both homosexual men and heterosexual women. Although DeBord, Wood, Sher, and Good (1998) found that substance abuse among homosexuals is equal to abuse rates among heterosexuals, higher prevalence among homosexuals was found in more recent studies (Gilman et al., 2001; Sandfort et al., 2001, 2006; Wang et al., 2007). A meta-analysis by Marshal et al. (2008) showed that drug abuse among homosexuals is 2.89 times higher than general substance abuse among heterosexuals.

In a nationally representative household telephone interview survey of the general United States female population, Drabble and Trocki (2005) found that compared with exclusively heterosexual women, the odds of THC use—marijuana, hash, THC, or "grass"—was 4.70 (odds ratio) for homosexual women and 6.09 for bisexual women.

Stall et al.'s (2001) household-based probability telephone study found not only that 85 percent of homosexually behaving men reported alcohol use, but also that 52 percent reported recreational drug use of any kind.

Cochran, Ackerman, Mays, and Ross (2004) assessed and compared drug use of a nationally representative sample of 194 homosexually experienced and 2,844 heterosexually experienced men and women. The following results were reported:

- 37.2 percent of *homosexually active men* reported lifetime use of *cocaine,* compared to 19.5 percent of heterosexual men.
- 34.7 percent of *homosexually active men* reported lifetime use of *hallucinogens,* compared to 18.0 percent of heterosexual men.
- 30.8 percent of *homosexually active men* reported lifetime use of *inhalants,* compared to 9.8 percent of heterosexual men.

- 38.5 percent of *homosexually active women* reported lifetime use of *cocaine,* compared to 12.1 percent of heterosexual women.
- 22.9 percent of *homosexually active women* reported lifetime use of *hallucinogens,* compared to 9.9 percent of heterosexual women.
- 14.3 percent of *homosexually active women* reported lifetime use of *inhalants,* compared to 5.0 percent of heterosexual women.

Cochran et al. (2004) concluded, "Across studies, lesbians and gay men evidence higher prevalence of use and problems with illicit drug use" (p. 994).

Thiede et al. (2003) reported a cross-sectional sampling survey that was conducted in seven major urban centers in the United States. The sample included 3,492 young men who had sex with men. The survey revealed that 66 percent of the homosexual men reported using illicit drugs; 28 percent had used three or more drugs, and 29 percent had used drugs frequently (once a week or more).

Concerning whether substance use begins before or after the realization that one experiences homosexual attraction, Craig (1987) stated, "One question not answered by prevalence data is whether homosexuality preceded drug abuse, or whether drug abuse preceded homosexuality" (p. 1145). However, since initial homosexual attraction occurs at a mean age of 10 years (Whitam & Mathy, 1986), it appears likely that for many the experience of homosexuality precedes substance abuse.

Do societal pressures place homosexuals at high risk for substance abuse, as suggested by Weinberg (1972)? The U.S. Department of Health and Human Services (DHHS) concluded that while factors such as social stigma and discrimination are widely believed to place homosexual men and women at higher risk for developing substance abuse and other difficulties, existing research fails to document this belief (DHHS, 1994).

Summary of Substance Abuse Among Homosexuals

Twentieth-century research revealed that homosexuals are about three times more likely to abuse or be dependent on drugs or alcohol than the general population. Studies have shown that nearly two thirds of homosexual teens abuse alcohol. In the female homosexual community, alcohol use is even more widespread and is often used as a gateway to sexual activity.

Undue Risk-Taking, Particularly With Life or Health

HIV/AIDS Risk

The prevalence, consistency, and relapse risk-taking behavior for HIV and AIDS is much higher among homosexuals than among heterosexuals. Risky sexual behaviors are so widespread in the homosexual community that risk education programs over the past two decades have clearly failed, with seroconversion rates now approaching those before the programs started.

The incidence of apparent heterosexual transmission of HIV/AIDS in the United States was rather low during the 20th century, making up approximately 10 percent of the total cases (Huether & McCance, 1996). However, the *risk* of HIV/AIDS among homosexuals at that time was approximately 430 times greater than among heterosexuals (Odets, 1994a) because of the higher infection rate present in the homosexual population, the larger number of partners among homosexuals, and the greater likelihood of transmission through anal as opposed to vaginal sex. Homosexuals consistently represent the highest rates of HIV/AIDS cases in the United States. For example, in a 1990 report, close to 96 percent of San Francisco's AIDS cases were homosexual men (Ekstrand & Coates, 1990). In another cohort of 508 homosexual men in San Francisco, 50 percent tested positive for HIV antibodies (Hays, Turner, & Coates, 1992).

There is no significant difference between HIV-positive and HIV-negative homosexual groups in the way they express their sexuality. A sample of 121 from each group showed a similar variety in sexual partners and behaviors, and both place themselves in the same types of risk-related situations (Meyer-Bahlburg et al., 1991).

One of the most significant risks in the 1990s was unprotected anal intercourse: one third of male bisexuals had engaged in unprotected anal intercourse in the previous 6 months (McKirnan, Stokes, & Doll, 1995), two thirds in the previous 18 months (Signorile, 1995), and 23 percent in the period just before the study (Myers, Godin, Lambert, Calzavara, & Locker, 1996). Only about 12 percent reported that they had never engaged in unprotected anal intercourse (Myers, Godin, Calzavara, Lambert, & Locker, 1993).

In a study of Canadian men, the proportions of those who participated in unprotected anal intercourse varied by city: 57.1 percent in Montreal, 73.3 percent in Ontario, and 56.3 percent in Vancouver (Myers et al., 1993). Researchers found varied rates of unprotected anal intercourse:

- 64 percent (Linn et al., 1989)
- More than 70 percent (McKusick, Coates, Morin, Pollack, & Hoff, 1990)
- 25 percent (D'Augelli, 1992)
- 41 percent (Osmond, Page, & Wiley, 1994)
- 27 percent in the last two months (Kelly, Sikkema, Winett, & Solomon, 1995)
- 95 percent reporting at least one incidence (Offir, Fisher, Williams, & Fisher, 1993)
- 52 percent, inconsistently or never (Rotheram-Borus, Hunter, & Rosario, 1994)

In one summary, Satinover (1996) calculated that 40 percent of homosexual men never used a condom during anal intercourse.

AIDS education, argued by pro-homosexual advocates to be essential in decreasing AIDS risk, essentially failed (Odets, 1994b). The vast majority of homosexual men with higher levels of AIDS education do not practice safer sex behavior. Canada's Talking Sex Project found that education did not increase behaviors to limit the risk of contracting HIV through anal sex (Myers, Godin, Calzavara, Lambert, & Locker, 1992). The researchers concluded that homosexual men repeatedly engage in unprotected anal intercourse despite known consequences.

Although previous studies gave some encouragement that the AIDS risk behaviors among homosexuals had decreased (Ekstrand & Coates, 1990; Martin, 1987), other researchers found that inconsistent condom use remained high (McCombs & White, 1990). Even when high-risk activities were reduced, this occurred among only a small percentage—and there was an especially small reduction in risky behavior for those participating in anal intercourse (McKusick, Horstman, & Coates, 1985).

Near the beginning of the AIDS epidemic, researchers found that while a large percentage of homosexuals adopted safer behaviors, a similar percentage continued to engage in risky behaviors (Siegel, Bauman, Christ, & Krown, 1988). And even though homosexuals practiced "safer sex" during some periods after AIDS became prevalent, they eventually relapsed from these safer practices to riskier, more common practices (Kelly et al., 1991; CDC, 1991). In longitudinal behavioral studies (1984–1991), more than one third of a sample of 310 homosexual men relapsed to risky sex behaviors, while fewer than 9 percent reported consistent no-risk behaviors (deWit, van den Hoek, Sandfort, & van Griensven, 1993).

When a dozen risk-reduction studies were reviewed, the researchers concluded, "Even using cross-sectional designs, the efficacy of health education interventions in reducing sexual risk for HIV infections [among homosexuals] have not been consistently demonstrated" (Stall, Coates, & Hoff, 1988, p. 883).

Sadly, HIV/AIDS education findings suggest that there is little or no observable benefit to educating homosexual men about their health risk (Pryor & Reeder, 1993). While risk knowledge is typically high among sexually active homosexual men, they also typically fail to reduce their high-risk activities (Kelly et al., 1990). Consistency is what matters: it only takes one incident of risk relapse to acquire AIDS. Because the actual transmission of a virus is not visible to the human eye, some homosexuals never fully see the risk of their behaviors. In addition, persons infected with HIV may be asymptomatic for many years. While erroneously thinking that they are disease-free, they may nonetheless spread the disease.

Even homosexual and bisexual men who know that they are infected with HIV continue to be promiscuous and seldom notify their partners of their HIV status. When researchers studied 111 men infected with HIV—93 percent of them identified as homosexual—the men collectively reported 929 individual sexual partners. Fewer than 6 percent of those partners were informed of their risk by these men, who knew they were infected with HIV yet carelessly infected others—in a few cases, deliberately—or at least put others at grave risk (Marks, Richardson, Ruiz, & Maldonado, 1992).

In another survey, 823 homosexual or bisexual men were interviewed on their knowledge about AIDS. They reported having many sexual partners and frequently using drugs. They were also unlikely to discuss safer sex with their partners. Only 1 percent reported that they exclusively practiced safer sex. In the six months before the study, the average number of sex partners for each was 11.4 (Linn et al., 1989).

While receptive anal sex with ejaculation poses the most common risk for HIV infection among homosexuals, evidence shows that oral transmission of HIV is also possible (Keet, 1992). Researchers document the presence of HIV seroconversion in homosexual men who received oral sex (Lifson et al., 1990).

Even with a condom, sex is not completely safe, since condoms can fail as often as 10 percent of the time (Goldsmith, 1987, as cited by Martin, 1990). Failure rates are also caused by errors in use (Martin, 1990). In addition, condoms are more likely to break during anal intercourse because it creates greater friction than vaginal sex, and other mechanical stresses are involved (DHHS, 1990) as the anus is used for a purpose for which it was not biologically designed.

By the early 1990s, approximately 60 percent of AIDS cases on the east coast and 90 percent on the west coast were related to homosexuality. Twenty-seven percent of the AIDS cases in the United States occurred in three cities with high homosexual populations: Los Angeles, New York, and San Francisco. At the time of the study, these cities had approximately 20 to 50 percent of the nation's total homosexual population (Kelly, St. Lawrence, & Brasfield, 1991). Specific homosexual neighborhoods were severely infected; San Francisco's Castro neighborhood and New York City's Chelsea Village were found to have an especially large number of AIDS cases (Bartlett, 1994). Although Los Angeles, New York, and San Francisco were considered "AIDS epicenters," homosexuals in smaller and less homosexually populated cities were also infected with HIV because of the potential and actual spread of disease from such epicenters to smaller communities (Ruefli, Yu, & Barton, 1992).

In 1988, the sexual behavior of homosexuals was studied among patrons of four Seattle gay bars; more than 400 surveys were completed. In the surveys, 29 percent of the respondents reported engaging in unprotected anal intercourse at least once in the two months prior to the survey. In 1994, the authors concluded that the rate of unprotected anal intercourse had not changed much since the findings of the 1988 study, despite increased knowledge about AIDS (Steiner, Lemke, & Roffman, 1994).

In a sample of 526 homosexual men from midsized cities, 37 percent admitted to engaging in unprotected anal intercourse in the three months before the study (Kelly et al., 1990). While those in the study were well educated and aware of the AIDS risk, risk-taking behavior was still commonplace—suggesting

that deeper psychological phenomena, not lack of education, motivate the high-risk behavior of homosexual men. A homosexual orientation predicts vulnerability to AIDS risk and relapse behaviors (Kelly, St. Lawrence, & Brasfield, 1991).

The San Francisco Young Men's Health Study, a household study of 380 unmarried men 18 to 29 years of age, revealed that 68 percent of homosexual and bisexual men had tested HIV seropositive. The researchers reported that even after they knew they were HIV positive, homosexuals continued to practice risky behavior and thus widened the epidemic (Osmond et al., 1994). Another researcher reported that homosexuals likely participated in unsafe sex because subconsciously they did not want to survive or because it gave them a way to more strongly identify with the homosexual community (San Francisco Department of Health, 1993).

In a sample survey of 6,000 men entering gay bars in 16 small American cities, researchers assessed sexual behaviors and predictors of risky sexual practices. Researchers also included in their definition of risky behavior a number of different male partners. These researchers documented that the men had a weak intention to use protection and believed that safer sex practices were not the norm in the homosexual community (Kelly et al., 1995). Lack of concern about the risk of "unprotected" homosexual sex persists in spite of the real dangers of its practice. One single act of unprotected anal intercourse with a 20- to 30-year-old homosexual man carries with it a transmission risk of about 1 in 165 (Satinover, 1996).

According to Dr. Linda Valleroy of the CDC, HIV rates are very high among young homosexual men, compared with the general population of youth in the United States (Russell, 2001). This is not surprising given that homosexual youth report a high incidence of unprotected anal intercourse (Lemp, Hirozawa, & Givertz, 1994).

Messina (1992) found that among street youth, 50 percent in New York and 40 percent in Seattle identified themselves as homosexual, and close to 10 percent were already infected with HIV. It is estimated that even more cases of infection were undetected or unreported, while the majority remained at risk. These youth represented fewer than 4 percent of the population at the time (Messina, 1992). Researchers in London also found that half of young male street sex workers were homosexual and that 21 percent of a sample of 50 reported that they had been diagnosed as HIV positive (West, 1993).

In another study, New York City homosexual and bisexual adolescent men reportedly used protection, such as condoms, only during the first year after they became sexually active (Rotheram-Borus, Rosario, et al., 1994).

Offir et al. (1993) conducted a qualitative exploratory research project consisting of open discussions with 41 homosexual men about the increase of AIDS-prevention behaviors. For many, the use of actual safer-sex practices was erratic, and "respondents did not express motivation to initiate further behavior change" (p. 62). One third reported unprotected insertive sex, and more than half "indicated a general reluctance to use condoms during oral sex" (p. 64). The respondents apparently thought that their risky behaviors were merely atypical, situationally based, and not a true health risk.

In some studies, homosexual men have been found to be apathetic about their HIV test results. Two thirds of those who volunteered for HIV testing did not even want to learn the results (Ostrow et al., 1994). This phenomenon was found in a multicenter AIDS cohort study of more than 1,000 homosexual men in Chicago from 1984 to 1990. The majority of homosexuals had unprotected intercourse and did not perceive their behavior as risky (McLean, Boulton, Brooks, & Lakani, 1994).

Anal intercourse and fellatio carry significant risk with or without a condom. In fact, the DHHS issued a warning from the Surgeon General in its publication, *Condoms and Sexually Transmitted Diseases . . . Especially AIDS* (1990), which states:

> Condoms provide some protection, but anal intercourse is simply too dangerous a practice. . . . Even if a condom doesn't break, anal intercourse is very risky because it can cause tissue in the rectum to tear and bleed. These tears allow disease to pass more easily from one partner to the other. (p. 7)

In another study of homosexual men who used condoms, 26 percent reported at least one condom breakage during usage (D'Augelli, 1992). The risk of condom failure (such as breakage or slippage) in a single episode is high for those who use condoms during anal intercourse (Thompson, Yager, & Martin, 1993).

In spite of realizing the health risks, some homosexuals argue for and attempt to justify unsafe sex, as in this example:

> Unsafe sex can emerge from good and honorable motives. Although dismissed by hard-line scientists, statements such as, "I want to please you," or "It seemed like the right thing to do," are not wimpish excuses but potential reasons. Unsafe sex is not irrational, but a different sort of rationality. (Davies, Hickson, Weatherburn, & Hunt, 1993)

In his article "Sodomy and Stigma," Bruce Parnell wrote, "We need to acknowledge that it is reasonable for people to want to f—k without condoms," and the most appropriate strategy is to encourage individuals to "consider for themselves what is and what is not appropriate behavior for themselves" (as cited in Molenaar, 1994, p. 2). This type of rhetoric was prevalent in the mainstream homosexual literature of the 20th century. The extreme phenomenon of deliberate anal intercourse without protection (now known as *barebacking*) is an illustration of this almost unprecedented attitude to risk (Parsons & Bimbi, 2007; Parsons, Kelly, Bimbi, Muench, & Morgenstern, 2007).

A review of qualitative data revealed that many homosexuals were not even concerned with the risk—for them, having unprotected sex outweighed any risk of disease, even though at the time AIDS had a virtually 100 percent mortality rate. Failure to protect oneself from disease goes beyond apathy, lack of information, cognitive distortion, or perception—rather, such failure suggests, at least in some cases, a pathological lack of self-care.

Homosexual men regularly reported that they practiced unsafe sex out of boredom or despair (Kirp, 1995). They maintained that condoms were a barrier to intimacy and that their risky behaviors played "an important role in their lives" (Brendstrup & Schmidt, 1990). But the consequence of this pathological thinking is the probability that within 20 years—even assuming the development of antiviral therapy (Yazdanpanah et al., 2002)—a third or more of all homosexual men now at age 20 would be dead from AIDS (Kirp, 1995).

A significant number of homosexually active people, aware of the risk and despite their knowledge, continue to engage in unsafe sexual practices. This is highly pathological. Some argue that risk-taking homosexuals are not representative of the whole, and this is a potentially valid point that could only be addressed by research studies using random sampling or some other method of representative sampling. However, it is also possible that the risk-taking of the homosexuals in the above studies is fairly representative of the majority of homosexual males. More rigorous research is needed to resolve this research question. Because research to date fails to show a psychological difference between homosexual men practicing safer sex and those practicing risky sex (Siegel, Mesagno, Krown, & Christ, 1989), it is possible and perhaps likely that even a majority of those who practice safer sex at one point in time will subsequently lapse into practicing riskier sex.

Some researchers suggest that cognitive distortion may be a causal explanation for risk-taking sexual behaviors among male homosexuals. When homosexual men interpreted the riskiness of their behaviors, they were found to evade the facts, using a variety of misconceptions (Bauman & Siegel, 1987). In a different but perhaps parallel finding, Brenner (1991) found in psychoanalytic work with homosexual men that some appear to have an unconscious wish to develop AIDS.

Researchers have found that homosexual men differ cognitively from heterosexual men. Typically, they have more feminine traits. In a discussion of cognitive research, researchers concluded that in three groups of 38 subjects each (heterosexual men, heterosexual women, and homosexual men), the cognitive pattern of homosexual men was significantly different from that of heterosexual men, but not significantly different from that of heterosexual women (McCormick & Witelson, 1991).

Some of this disregard for one's own well-being may be attributed to social isolation. Many homosexuals with AIDS have been left alone and estranged from family. Ethnographic fieldwork in Houston between 1984 and 1991 revealed that of the examined individual cases of homosexual men with HIV/AIDS, all but one lived alone. But AIDS alone does not appear to cause social estrangement. In the first part of the ethnographic work, a high level of family estrangement was found independent of the AIDS phenomenon among 64 of the men who were studied (Lang, 1991).

Have there been reductions in sexual risk-taking among heterosexual males over time? It appears not. Sexually risky behavior among HIV-positive homosexuals in the 21st century continues to be highly problematic for individuals and society, despite education and decreased social stigma. Van Kesteren, Hospers, and Kok (2007) reviewed research on sexual risk behavior among HIV-positive men who had homosexual sex after the year 2000. The review included 53 published studies that reported on unprotected anal intercourse in cross-sectional and longitudinal surveys of HIV-positive men who had sex with men (MSM), and MSM with mixed HIV status. The men in the studies were self-identified as homosexual, bisexual, or just men who have sex with other men.

Van Kesteren et al.'s (2007) findings indicated high levels of unprotected anal intercourse among HIV-positive MSM, particularly those whose partners were HIV-negative or who had unknown HIV status. Studies of MSM of mixed HIV status found that the rate of unprotected anal intercourse among HIV-positive MSM was much higher than that of HIV-negative MSM. Furthermore, the prevalence of unprotected anal intercourse among HIV-positive MSM had increased in recent years. Although studies indicated that HIV-positive MSM had adopted some risk-reduction strategies, roughly two in five HIV-positive MSM continued to engage in unprotected anal intercourse, for which the risks and consequences are well known. Schackman et al. (2008) recently reported similar results.

An international survey of increased risk for many countries showed increased risk of HIV infection for homosexual men compared with heterosexual men in all countries/regions, even in Africa, where there is a high incidence of HIV infection among heterosexuals (Baral, Sifakis, Cleghorn, & Beyrer, 2007). Even with retroviral therapy, the mean life expectancy among those who are HIV positive seemed to increase only from about 10 years to perhaps rather more than 15 years (Yazdanpanah et al., 2002).

Homosexual Women and HIV/AIDS

At a New York City STD clinic, 17 percent of homosexual women were HIV positive compared with 11 percent of exclusively heterosexual women, a difference that was statistically significant (Bevier, Chiasson, Heffernan, & Castro, 1995). Women who were classified as homosexual were mostly bisexual, rather than exclusively homosexual.

In a study of homosexual and bisexual women in the San Francisco and Berkeley area, 6 of the 498 surveyed had tested positive for HIV. That rate of 1.2 percent exceeded the rate of 0.35 percent among

women in general (Lemp, Hirozawa, & Givertz, 1995). These figures may be suspect, however, since all contact was on the street and because the sample may not have been representative.

Another California survey of homosexual women by the San Francisco Department of Health (1993) found that 22 percent reported that they had sex with a man during the previous three years, and 47 percent of those reported that they did not always use a condom. As written in *Newsline*:

> Over 10% of the women surveyed were injection drug users, and of this group, 71% have shared needles. It also appears that lesbians and bisexual women were much more likely to have sex and share needles with gay or bisexual men than heterosexual women [were]. (LaBarbera, 1994, p. 9)

Summary of HIV/AIDS Risk

In the 20th century, HIV/AIDS risk was approximately 430 times greater among homosexuals than among heterosexuals. There was a significant decrease in the numbers who became HIV positive only for a brief time after the onset of the AIDS epidemic. Empirical evidence indicates that the numbers rose again as homosexual men relapsed into higher-risk sexual behavior patterns. Having HIV/AIDS did not curtail the sexual behaviors of a large percentage of homosexual men. Researchers found very little practical difference between the sexual risk-taking behaviors of the HIV-positive and HIV-negative homosexual groups.

Unprotected anal sex among homosexual men was found to be commonplace. Homosexual youth reported a high incidence of unprotected anal intercourse, and HIV was very prevalent among young homosexuals compared to the general population of youth in the United States. Despite increased knowledge regarding the health risks of specific homosexual behaviors and decreased social stigma for homosexually-identified individuals, the situation regarding HIV/AIDS among homosexuals remains life-threatening to individuals and problematic for society.

In 2005 the risks of acquiring HIV from a single act of unprotected sex within the male homosexual community in the United States remained about 500 times greater than within the heterosexual community. (Data assumptions: 25 percent of the male homosexual population is HIV positive [CDC, 2005], compared with 0.2 percent of the heterosexual population [UNAIDS/WHO (2005)]; and 66 percent of HIV-positive cases are among the male homosexual community.)

Homosexual men have three times the median number of partners compared with heterosexual men (Laumann, Gagnon, Michael, & Michaels, 1994). No other group of comparable size in the population routinely and knowingly exposes itself to such life-threatening health risks in spite of educational campaigns.

Sexually Transmitted Diseases/Health Risks

Homosexuals have been found to be at particular risk of infectious diseases and other related health issues because of their sexual practices (Fluker, 1983).

Fluker (1976) and Fluker and Cross (1981) reported that homosexuals accounted for a large and disproportionate percentage of STD cases, and that they have long flooded medical centers with STD-related conditions.

Lifetime prevalence for STDs in homosexual men was 75 percent compared with 16.9 percent for heterosexual men (Laumann et al., 1994). In one independent study of more than 4,000 homosexual men, 78 percent had had at least one STD (Handsfield, 1981). In *The Spada Report,* two thirds of the respondents reported STDs (Spada, 1979).

Various researchers have concluded that homosexual men incur a greater risk of contracting STDs when compared with heterosexual men. Researchers report a greater risk among homosexuals for:

- Syphilis and gonorrhea (CDC, 1979; Darrow, Barrett, Jay, & Young, 1981; Fluker, 1983)
- Gonorrhea, syphilis, and human papillomavirus (HPV) infections (Handsfield & Schwebke, 1990)
- Gonorrhea, syphilis, and anal warts (Judson, Penley, Robinson, & Smith, 1980)
- HPV and anal cancers (Surawicz et al., 1995)

In a comparison study, anti-HIV antibodies were found in 30 percent of homosexual men but in only 12 percent of heterosexual men (Corey & Holmes, 1980). In another study conducted in Seattle in 1980, Handsfield (1981) found that at least 43 percent of a sample of 102 cases of hepatitis B virus (HBV) were homosexual men. This prevalence was disproportionately high because numerous population studies have documented that homosexually behaving men constitute only 2 to 3 percent of adult males (Laumann et al., 1994; Whitehead & Whitehead, 2007).

Gastrointestinal symptoms were found to be high among homosexual men and were often associated with STDs (Rompalo, 1990). Enteric bacterial pathogens that affect the intestines and cause complications—including shigellosis, giardiasis, amebiasis, infestations, and threadworms—were particularly prevalent among homosexual men (Fluker, 1983; Quinn, 1986; Smith & Singer, 1994), but were much rarer among heterosexual men.

Of men attending an STD clinic in Houston, a significantly higher frequency of human cytomegalovirus (HCMV) was found in the urine of homosexual men: 18 percent compared to 4 percent in heterosexual men (Greenberg et al., 1984).

Homosexuals are also more frequently exposed to ectoparasites, such as pubic lice *(Pthirus pubis).* One researcher found that 69 percent of homosexual men reported a history of these ectoparasites (Billstein, 1989). A history of scabies was also reported in 22 percent of homosexuals in the study by Jay and Young (1979). Another researcher found that anal intercourse often produces acute and chronic *pruritis ani* (anal itching) (MacAlpine, 1953).

Homosexual men also expose themselves to biological hazards more often than the general population. For example, common activities such as fisting, scat play (*coprophilia,* or sex involving feces), and sadistic and masochistic sexual practices expose homosexual men to blood and open wounds—often with multiple partners.

Anal intercourse is in fact maladaptive to human biological design. While the vagina has natural lubrication and a wide opening, the anal canal is small and dry, resulting in injury if sexually penetrated (Ketterer, 1983). In addition to its natural lubrication, the vaginal wall is relatively tenacious and cleaner than the rectum. In terms of unprotected intercourse, vaginal sex is safer than anal sex. Not only can the anus tear, but there is a possibility feces will enter the insertive partner's bloodstream (Satinover, 1996).

Anal intercourse readily damages the upper rectum and ruptures the peritoneum. Continued stretching and displacement of the anus leads to problems in control of gas and feces, and anal penetration puts the anal sphincter muscle at risk, causing chronic incontinence or urgency of defecation (Miles, Allen-Mersh, & Wastell, 1993). Homosexual men have a disproportionate rate of anal fissures, rectosigmoid tears, penile edema, and hemorrhoids (Owen, 1985). Kaposi's sarcoma, a lethal skin cancer, is disproportionately found in homosexuals (*Lancet,* 1981, as cited by West, 1983) and is considered an opportunistic infection related to AIDS.

Induced immune dysregulation not related to AIDS can be brought about by contact between homosexual men—the exchange of sperm antibodies alone are most likely responsible for marked suppression of the immune system (Mavligit, 1984). Even in the absence of symptoms, homosexuals have been found to have a surprisingly high level of immune dysfunction (Greenberg et al., 1984).

Homosexual women were also found to be at higher risk for STDs and other health problems. For example, the rate of bacterial vaginosis is 2.45 times higher among homosexual women than among heterosexual women (Evans, Scally, Wellard, & Wilson, 2007). Oral-genital sex common to homosexual women puts them at risk for herpes. Since heterosexual contact is also common among homosexual women (80 percent of homosexual women reported heterosexual contact in the past), they are at a dual risk for STDs (Johnson & Palermo, 1992). Homosexual women who report heterosexual histories are also more likely to report a history of gonorrhea or syphilis (Ernst & Houts, 1984). The men with whom homosexual women have sex are frequently drawn from the homosexual community, which they consider less psychologically threatening but which also exposes them to higher medical risks.

Analingus

According to Corey and Holmes (1980), "Diaries concerning sexual behavior kept by homosexual men showed that the acquisition of hepatitis A virus infection was correlated with frequent oral-anal contact" (p. 435). In the 1991 Canadian Men's Survey, 33.7 percent of men who have sex with men reported practicing insertive analingus and 40 percent practiced receptive analingus in the three months prior to the study (Myers et al., 1993). The act of analingus is not found among heterosexuals (McWhirter & Mattison, 1984).

Suicide

Researchers using methodologically strong studies document that suicidality is more strongly associated with homosexual orientation and behavior than with heterosexual orientation and behavior (Fergusson et al., 1999; Herrell et al., 1999; King et al., 2008). This finding is consistent with the results of older studies.

In a systematic study of 57 homosexual women and 43 single heterosexual women, researchers found that 23 percent of the homosexuals had attempted suicide compared to 5 percent of the heterosexuals (Saghir, Robins, Walbran, & Gentry, 1970). When homosexual and heterosexual women in prison were matched and compared, the homosexual women reported significantly more suicidal attempts (Climent, Ervin, Rollins, Plutchik, & Batinelli, 1977). DHHS reported that more than one third of suicides in the total population were committed by homosexual men—figures that put them at least two to three times more likely to commit suicide than the general population. Researchers conclude, "Increased receptive anal sex behavior may in itself be considered a form of avoidant coping or suicidal behavior" (Ostrow et al., 1994, p. 550).

In a study of 52 homosexual college men, researchers found that 55 percent reported a history of suicidal ideation (Schneider, Farberow, & Kruks, 1989). A review of three large, well-designed studies found that homosexual men and women attempted suicide two to seven times more often than heterosexual comparison groups (Saunders & Valente, 1987). While attempts of or ideas about suicide did not necessarily mean completion of suicide, such attempts do increase the risk factors, leading to the conclusion that homosexuals are at greater risk for suicide completion.

The results of more recent methodologically stronger studies confirm and expand these earlier findings. De Graaf, Sandfort, and Ten Have (2006) conducted a random, nationally representative household survey of the general population in the Netherlands, which has a tolerant social climate toward homosexuality (Sandfort et al., 2001). The participation rate was 69.7 percent and the sample consisted of 125 men and women reporting homosexual behavior and 5,873 men and women reporting only heterosexual behavior. De Graaf et al. reported the following at risk odds ratios (OR):

- Lifetime death wishes (OR 5.93): 26.8 percent of homosexual men showed a lifetime risk of experiencing death wishes vs. 5.8 percent of heterosexual men.
- Lifetime suicide contemplation (OR 7.74): 40.2 percent of homosexual men showed a lifetime risk for contemplating suicide vs. 7.8 percent of heterosexual men.
- Lifetime deliberate self-harm (OR 10.23): 14.6 percent of homosexual men showed a lifetime risk for deliberate self-harm vs. 2.0 percent of heterosexual men.
- Lifetime suicide contemplation (OR 2.12): 23.3 percent of homosexual women showed a lifetime risk for contemplating suicide vs. 2.3 percent of heterosexual women.

Herrell et al. (1999) reported a study from the population-based Vietnam Era Twins Registry of a sample of 103 middle-aged male-male twin pairs "in which one member of the pair reported male sexual partners after age 18 years while the other did not." Some 6,434 pairs were concordant for no adult same-gender partners, and 16 pairs were concordant for any adult same-gender partners. Herrell et al. found, "There is more than a 4-fold increase in *suicidal ideation* (OR, 4.1) among the twins reporting a same-gender sexual orientation compared with their co-twins discordant on this measure" (p. 871). Also, "Twins reporting a same-gender sexual orientation are 6.5 times more likely to report having *attempted suicide* than their co-twins" (p. 871).

Suicide among homosexual youth

Studies of youth who have attempted suicide have revealed that a disproportionately high number are homosexual (D'Augelli & Hershberger, 1993; Hendin, 1992; Prenzlauer, Drescher, & Winchel, 1992; Rich, Fowler, Young, & Benkush, 1986). Gibson (1986) concluded that homosexual and bisexual youth are three times more likely to attempt suicide than are heterosexual youth. Findings from other studies are remarkably similar (D'Augelli & Hershberger, 1993; Proctor & Groze, 1994; Remafedi, Farrow, & Deisher, 1991; Rotheram-Borus, Rosario, et al., 1994; Tielman, Carballo, & Hendricks, 1991).

Recent studies with better methodological control (i.e., randomized sampling and better control groups) continue to report much the same results: suicide is significantly more prevalent among homosexuals than heterosexuals (de Graaf et al., 2006; Fleming, Merry, Robinson, Denny, & Watson, 2007; Hegna & Wichstrøm, 2007; Lester, 2006; Meads et al., 2007; Safren & Heimberg, 1999; Sandfort et al., 2001, 2006; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003; Warner et al., 2004). Among homosexual men the prevalence of suicide is close to three times higher than among heterosexual men. The suicidality among homosexual women was almost entirely connected to their increased mental illness (such as depression), but it was not related to mental illness in homosexual men.

In one Netherlands study (de Graaf et al., 2006) involving 7,000 participants, younger homosexually-oriented people were found to be at greater risk of suicidality than older homosexually-oriented people. This suggests that liberalization of social mores in the Netherlands has not lowered the risk of suicidality in the younger generation.

Much information is now available about motivations for suicide, and this data shows that the predominant motives for homosexual people are relationship breakup and self-hatred. No young person ever welcomes the discovery that he or she is attracted to the same sex, a discovery that makes them feel very different at the precise time when they are trying to conform to the standards and motivations of their peers. According to D'Augelli (as cited in Paul et al., 2002), the time of greatest suicide risk for youth is when they believe they are homosexual but have not yet told anyone. At that point, overt

discrimination issues or the other issues we touch on later are on average much less important, and the dominant motive is self-hatred.

The precipitating problems found in most of the studies were the breakup of romantic relationships, other relationship difficulties, hatred of being homosexual, depression, substance addiction, and social discrimination. Various studies ask homosexuals who attempt suicide about the most common motives in their suicidal attempts. It's difficult to interpret the data—the factors are interrelated and there are classification difficulties. Because the studies span almost 30 years, there may have been some relative changes with time. Notable are the sparse numerical estimates of the significance of social discrimination as a motivator for suicide. Indeed, there is much skepticism about whether discrimination is real or only perceived, and whether it is a primary or secondary motivating factor.

Romantic relationship difficulties

Bell and Weinberg (1978) found that 43 percent of suicide attempts among white homosexual men and 67 percent among white homosexual women involve the distress involved in ending a romantic relationship. Perhaps reflecting this, Bradford, Ryan, and Rothblum (1994) found that 44 percent of nonsuicidal people in their study reported problems with lovers as the most common complaint. Hendin (1995), whose specialty is the study of suicide, found that among whites, homosexual rejection by a same-sex person was the usual precipitating event for the suicidal attempt. However, this also included nonromantic rejection. "Suicidal homosexuals typically attributed all their unhappiness to rejection," Hendin concluded, "but it was clear that unhappiness and rejection formed intrinsic parts of their relationships" (p.137).

The researchers note the life-or-death, "I can't live without you" quality that suicidal homosexual youth give their relationships. Hillier, Turner, and Mitchell (2005) found that "given the hostility of their environment, having someone who cared was particularly important and breakups were particularly devastating" (p. 44). Bartholow et al. (1994) found that 17 to 20 percent of their suicidal sample had ended a primary relationship in the previous four months. Among homosexual youth, Remafedi et al. (1991) found that 19 percent cited romantic problems as the reason for their suicidal attempts.

Since there are approximately three to four times as many partners among members of the homosexual community as there are in the heterosexual community (Laumann et al., 1994), it is tempting to think that having so many more partners could be an important factor explaining the higher level of suicidal attempts. However, the research findings for the following variables show that an adequate explanation is not so simple.

General relationship difficulties (with family, peers, etc.) of a rather variable nature were cited as significant suicidal ideation motivators by 44 percent of Remafedi et al.'s (1991) group. Bradford et al. (1994) studied a group in which 34 percent mentioned family problems and 10 percent mentioned problems with friends. D'Augelli et al. (2005) found that parental disapproval was a factor. Other researchers recorded that homosexual teens reported relationship-related reasons for attempting suicide (Buhrich & Loke, 1988; Dubé & Savin-Williams, 1999; Safren & Heimberg, 1999).

Self-hatred and depression

Thirty-seven percent of Bell and Weinberg's (1978) convenience sample of suicidal homosexual adults "could not accept themselves"; 21 percent of Bradford et al.'s (1994) group could not deal with being homosexual; and one third of Remafedi et al.'s (1991) group cited the same problem. About half of the youth in D'Augelli et al.'s (2005) group reported that they attempted suicide because they hated being homosexual. Hammelman (1993) placed the figure as high as 75 percent. Buhrich and Loke (1988) and Dubé and Savin-Williams (1999) also reported discontent with being homosexual as a suicidal risk factor.

We admit that some researchers opine that if society put its stamp of approval on homosexual behavior, such self-hatred would be removed. However, we think this view is unrealistic, because suicidality figures for countries more tolerant of alternative lifestyles than the United States (such as the Netherlands) do not, in fact, support this assumption (Sandfort et al., 2001). Also, depression itself is associated with suicide (Dubé & Savin-Williams, 1999). Depression experienced by homosexuals could originate from factors other than lack of self-acceptance of, or self-hatred for, being homosexual, but the above researchers, if they studied other depression risk factors, do not report them.

Substance abuse

Substance abuse is independently associated with suicide and was certainly high in the homosexual groups studied. Remafedi et al. (1991) found that 15 percent of their young group reported this as a variable that may have influenced their attempting suicide. Five studies (de Graaf et al., 2006; Eisenberg & Resnick, 2006; Herrell et al., 1999; Lester, 2006; Safren & Heimberg, 1999) report that when substance abuse and depression are factored out, there is still an influence uniquely attributable to sexual orientation. By contrast, de Graaf et al. (2006) found that suicidal attempts by homosexual women—but not by homosexual men—were entirely accounted for by increased mental illness, presumably depression.

Discrimination

Friedman, Koeske, Silvestre, Korr, and Sites (2006) reported that bullying is a suicide risk factor for homosexual youth. However, the hypothesis that social discrimination and bullying can explain all suicidality in homosexually-oriented youth is not supported by the research.

For both homosexual teens of both genders, Shaffer, Fisher, Hicks, Parides, and Gould (1995) reported that suicidal attempts are not subsequent to a social stigmatization episode. Remafedi et al. (1991) found that both those who attempted suicide and those who did not had similar experiences of discrimination, and concluded that discrimination must have only a minor effect on subsequent suicidal behavior. Hendin (1995) found no evidence that discrimination was a significant factor in suicidal attempts. Likewise, Hershberger, Scott, and D'Augelli (1995) found that victimization was not directly related to suicide and that an incident of social discrimination toward a homosexual youth could be ameliorated by the youth's self-acceptance and family support. The researchers concluded that independent suicidal thinking was a more important suicidal risk factor than prior victimization.

Significantly, Paul et al. (2002) found that suicide risk remains constant in spite of changing social attitudes and greater social tolerance—meaning that factors other than societal discrimination are prompting suicidal attempts. Warner et al. (2004) found that among suicidal homosexual youth, physical attacks were 70 percent greater and bullying was 40 percent higher than for a nonsuicidal homosexual group, suggesting that physical attacks and bullying were significant factors. However, these have much smaller effects than other factors already discussed, implying that the effects of direct discrimination are not numerically overwhelming.

Hillier et al. (2005) did not separate suicide from other self-harm, including self-mutilation, but the physical and mental abuse group could have had as high as two times the suicidal attempts as the nonabused group. Homophobia was cited by 35 percent of their group as the reason for suicidal attempts or ideation—but no separate figures were given for suicidal attempts, and the majority of their sample probably experienced ideation. Friedman et al. (2006) also cited bullying as a suicide factor for young people.

In the relatively homosexual-friendly Netherlands, de Graaf et al. (2006) thought *perceived* discrimination might have been a greater factor, because the lesser discrimination than in other countries did not lead to lower suicide prevalence. Sandfort, Bakker, Schellevis, and Vanwesenbeeck (2009) found

homosexual suicidality was entirely accounted for by coping style, leaving no room for influence of societal stigma. Fitzpatrick, Euton, Jones, and Schmidt (2005) found that atypical gender role was more tightly correlated with suicidality than actual sexual orientation.

Summary regarding suicide rates

Overall, the preceding studies suggest that homosexuals encounter an unusually high rate of intimate relationship difficulties, which lead them to attempt suicide. Depression and substance abuse are causal variables for suicidal attempts, but discrimination—far from being a universal explanation—seems to have relatively and absolutely less influence than hypothesized. Self-hatred appears to be another important factor in itself, but the development of self-hatred among homosexuals is not shown to be due solely—or primarily—to social discrimination either. Researchers have documented that societal discrimination itself accounts directly or indirectly for at most a small part of the higher incidence of suicidality among homosexuals. As Bailey (1999) states, "It would indeed be surprising if anti-homosexual attitudes were not part of the explanation of increased suicidality among homosexual people, but this remains to be demonstrated" (p. 884).

Life and health are uniquely attacked by and among homosexuals, producing increased medical and mental health problems and mortality. This phenomenon does not seem to be primarily connected with discrimination issues in society at large. Instead, the greatest factors contributing to an increased suicide rate seem to be attitudes among homosexuals themselves and their responses to the breakup of the relationships that they enter so intensely.

We must also consider the existence of as-yet-unidentified factors, about which some prominent writers have theorized—including the possibility of a developmental disorder, either biological, psychological, or both—and problematic lifestyle factors common to the homosexual community.

We again quote Bailey (1999), writing in the *Archives of General Psychiatry,* "Homosexuality represents a deviation from normal development, and is associated with other such deviations that may lead to mental illness" (p. 884). Bailey proposes several possible interpretations of the findings. Bailey concludes that while social oppression is a likely stressor, researchers have not demonstrated that social oppression is the sole or primary source of the greater prevalence of mental illness among homosexuals.

A second possibility, Bailey speculates, is that since evolution naturally selects for heterosexuality, "homosexuality may represent developmental error" (p. 884). While he does not fully elaborate on this suggestion, he says some research links homosexuality to "developmental instability" (p. 884) similar to minor physical anomalies such as left-handedness. A third possibility concerns the gender-atypicality of homosexuals as a group; homosexual men, being as a group more feminine, may be exhibiting more female-like types of neuroticism.

A fourth possibility is that the increased psychopathology experienced by homosexuals may be due to "lifestyle differences" (particularly promiscuity and fear of sexually transmitted diseases). Lifestyle differences—including the homosexual community's great stress on physical attractiveness and thinness—might also explain the much higher rate of homosexual men with eating disorders.

To understand why homosexuality is linked with psychopathology, Bailey calls for more research—particularly research that is free of politicization and that does not avoid exploring unpopular hypotheses (cf. Byrd, 2006, 2008).

Psychological Maladjustment Studies

We recognize that the older literature in this section is less academically rigorous than more recent studies. None of these tests was sufficient to unequivocally identify homosexually-oriented people without

a personal interview about their sexuality. We discuss these older findings because newer researchers using more methodologically rigorous methods draw similar conclusions.

Hooker's (1957) research is frequently cited as "proving" there is no greater pathology in homosexual men—something which her research was not designed to do. She compared small, select samples of homosexual and heterosexual men, and independent judges found no differences in overall adjustments on Rorschach protocols; in fact, the judges could not distinguish the homosexuals from the heterosexuals. Although Hooker's study showed little difference between the two groups, this was at least partially due to sampling bias. The study excluded from participation homosexuals with obvious pathology. Although no differences in overall adjustment were found within the select group and through the study's limited projective testing method, it still was possible to distinguish the two groups from results of the Thematic Apperception Test (TAT) protocols, which were designed to assess the subject's unconscious, repressed motives, among other things.

Numerous studies after Hooker have failed to support Hooker's finding of no difference in overall adjustment. A number of different studies using a variety of psychological tests have found significant differences in psychological adjustment scores between heterosexuals and homosexuals. Overall, the outcomes of research using psychological tests reveal a trend that correlates homosexuality to high neuroticism (van den Aardweg, 1985). A number of these studies are discussed below.

Minnesota Multiphasic Personality Inventory (MMPI)

After administering the Minnesota Multiphasic Personality Inventory (MMPI) to a group of reportedly "normal homosexuals," Loney (1971) found that the F-scale score—a deviant, or rare, response scale—was greater among homosexuals than heterosexuals. This meant that the homosexual group in Loney's study sample responded to items in ways that are rarely endorsed by individuals who are free from serious psychopathology.

Manosevitz (1971) administered MMPIs to nonclinical samples of homosexuals and heterosexuals and found that the profiles of homosexuals appeared more depressed, sociopathic deviant, feminine (for men), paranoid, anxious, and schizophrenic, and less skilled socially than did the profiles of the heterosexuals. Cubitt and Gendreau (1972) compared the MMPI scores of homosexual and heterosexual prisoners and found that the profiles of homosexuals were more histrionic (theatrical) and suggested more somatic concerns (such as undue concern with body appearance).

Braaten and Darling (1965) found that the MMPI profiles of overt homosexuals appeared more sociopathic deviant, and that those of covert homosexuals suggested lower social skills. Among both groups, the profiles of homosexual men appeared more feminine than the profiles of heterosexual men.

Doidge and Holtzman (1960) rated Air Force trainees for their degree of homosexuality. The researchers found that homosexual men were more feminine, hysterical, sociopathic deviant, paranoid schizophrenic, histrionic, and depressed, and that they had lower social skills and higher anxiety levels than did heterosexual men.

Oliver and Mosher (1968) compared both homosexual and heterosexual youth housed in a reformatory. They concluded, "The data suggests [sic] greater maladjustment on the part of homosexuals" (p. 101).

MMPI MF (masculinity/femininity) Scale

Lester (1975) found that five of seven studies reported that homosexual men had higher MF scores, meaning they were more feminine than the heterosexual men. Friberg (1967) concluded after his review that "in general, it appears that homosexuals do obtain higher femininity scores than heterosexuals" (p. 102).

California Psychological Inventory (CPI)

Compared with 66 heterosexual men, 60 homosexual men scored lower on the California Psychological Inventory scales of Wb (sense of well-being) and Sc (self-control), but higher on Scale 5 (sensitivity) (Hiatt & Hargrave, 1994).

Personality Factor Questionnaire (16PF)

In a community sample, Evans (1970) found that the scores of homosexuals who completed the 16PF were less emotionally stable, conscientious, and self-controlled, and more tense, tender-minded, suspicious, imaginative, apprehensive, and self-sufficient than the scores of heterosexuals. Evans observed that overall, the homosexual group resembled typical heterosexuals more than they resembled diagnosed anxiety neurotics, and that they appeared to be "mildly neurotic."

Using a forensic sample, Cubitt and Gendreau (1972) found that the homosexuals had less emotional stability and were less experimenting and more shrewd. After reviewing these studies, Lester (1975) concluded, "Again, although differences are not consistent, the trends are for greater maladjustment or neurosis in the homosexual" (p. 103).

Gough Adjective Checklist

Evans (1971) compared homosexuals and heterosexuals on the Gough Adjective Checklist. The homosexual group endorsed items associated with being less self-confident, less dominant, and more succorant, having less endurance, less need for achievement and order, more need for abasement, and more counseling readiness. On the MF scale, the homosexual men scored as more feminine. The homosexual group checked more unfavorable adjectives and fewer personal adjectives (suggesting a lower degree of emotional connectedness and less self-knowledge). The two groups did not differ on the number of favorable adjectives checked, including self-control, labiality, intraception, nurturance, affiliation, heterosexuality, exhibitionism, autonomy, aggression, change, and deference. On the MF scale, the homosexual men scored as more feminine. Evans concluded that homosexuals appeared more neurotic overall.

Other Tests

Grygier (1958) compared neurotic men on the Dynamic Personality Inventory. The homosexuals in the group scored higher on the questions related to passivity and the need for comfort/support, feminine narcissism, and feminine identification, and lower on questions related to masculine identification.

Siegelman (1972) administered the Scheier and Cattell's Neuroticism Scale Questionnaire (NSQ) to samples of homosexuals and heterosexuals. For the total sample, the homosexuals were more tender-minded, more submissive, more anxious, and had a higher total score. Siegelman then compared those respondents who had low femininity scores, and found that the homosexuals were more tender-minded than the heterosexuals. In general, the homosexuals were assessed as more neurotic and less well-adjusted. Siegelman also compared those homosexuals who belonged to a homosexual organization to those who did not and found that those in the organization were more depressed, more submissive, and had a higher total score.

Kendrick and Clarke (1967) compared homosexual psychiatric patients with nonpsychiatric heterosexuals and found differences in their self-concept on both the Semantic Differential and George Kelly's repertory grid. On the whole, the homosexuals had less favorable attitudes toward themselves, but they also had less favorable attitudes toward other concepts, such as justice, sex, and being normal.

Summary of Psychological Maladjustment Studies

The outcomes of research using formal, well-controlled, and validated psychological tests show a trend that correlates homosexuality to high neuroticism, such as emotional difficulties and disorders. After presenting the findings of various psychological tests comparing homosexuals and heterosexuals, Lester (1975) concluded that "homosexuals do seem to be less well-adjusted than heterosexuals" (p. 108).

Mental Health and Psychological Disorders

The current scientific consensus is that homosexuals have much greater psychopathology than the general population (Fergusson et al., 1999; Herrell et al., 1999; King et al., 2008; Sandfort et al., 2001).

While homosexual advocates agree that homosexual men and women display higher rates of drug and alcohol abuse and have higher risk of suicide, they argue that victimization and societal nonacceptance of homosexuality is responsible for these trends. However, researchers have not demonstrated a causal correlation between social victimization of homosexuals and the development of these disorders. For example, Hershberger et al. (1995) found that victimization does not directly relate to suicide in homosexuals. Savin-Williams (1994) concluded that there was no evidence of a causal link between stressors such as verbal and physical abuse and negative outcomes of homosexual youth, such as school problems, running away, substance abuse, prostitution, and suicide.

Notably, in a cross-cultural comparison of mental health in the Netherlands, Denmark, and the United States, Ross, Paulsen, and Stalstrom (1988) found no significant differences between the incidence of mental and emotional disorders reported by homosexuals in those countries. The lower level of social hostility toward homosexuals in the Netherlands and Denmark compared with the United States was not associated with a lower level of psychiatric problems among homosexuals in those European countries.

Results from the U.S. National Lesbian Health Care Survey and Canadian Surveys

The National Lesbian Health Care Survey (NLHCS)—conducted between 1984 and 1985—provided information on the mental health of 1,925 homosexual women from all 50 states and was considered the most comprehensive study at the time. Despite the fact that homosexual women were socially connected and had support systems, the researchers reported significant problems.

More than half of the women thought about suicide at some time, and 18 percent had attempted suicide. Forty-one percent had been raped or sexually attacked at least once, the overwhelming majority by men. Nineteen percent were victims of incest during childhood. This suggests that at least some of the mental health problems were caused by very negative life experiences rather than by societal stigma (Bradford et al., 1994; Ryan & Bradford, 1993).

Anxiety and Depression

Atkinson et al. (1988) found that regardless of whether a homosexual man is HIV-positive, he still reports significantly higher lifetime rates of anxiety disorder than does a heterosexual man.

Saghir and Robins (1971) found that homosexuals reported more depression than did heterosexuals. Pillard (1988) found that bipolar depression (including bipolar I, II, and cyclothymic types) occurred significantly more frequently in his sample of 51 homosexual men compared to a sample of 50 heterosexual men.

In a sample of HIV-positive homosexual men, Siegel et al. (1989) found significant levels of depression—even among those who reported positive socialization. While it could be argued that distress about developing AIDS may have caused this depression, other research suggests an alternative

explanation. Several samples of homosexual and bisexual men in HIV studies suggest that depression and anxiety are high in these populations and that their psychiatric morbidity began before the AIDS epidemic (Weinrich, Atkinson, McCutchan, Grant, & HNRC, 1995).

Cazzullo et al. (1990) found a higher psychopathological risk for homosexuals who were HIV-positive but symptom-free—but they concluded that the "major risk for HIV infection consists of subjects whose personal histories contain clear indications of psychopathological traits" (p. 290). Therefore, not only the HIV-positive homosexuals, but also those who were at risk before they were infected with HIV, showed psychopatholology.

Homosexual men report significantly higher rates of major depression than the general population, with or without HIV infection (Atkinson et al., 1988). In a comparison study of 28 HIV-positive, symptom-free homosexual men and 68 HIV-negative homosexual men, the two groups did not differ significantly in levels of depression, both at the beginning of the study and again at the followup (Jadresic, Riccio, Hawkins, & Wilson, 1994). In other words, receiving an HIV diagnosis had little effect on a man's level of depression. A diagnosis of fatal illness would normally be a crushing blow. The fact that it had no effect in raising depression levels suggests the extent of the depression with which many homosexual men may routinely struggle—and for which help should be available.

A study of HIV-negative homosexual African-American women showed that they were just as distressed as HIV-positive homosexual African-American men, and were even more distressed than HIV-negative men (Cochran & Mays, 1994). Although race and gender could be an argument here, researchers found that both homosexual men and homosexual women reported distress levels in excess of those previously reported in studies of both African-American and Caucasian men and women.

Nurius (1983) found that homosexuals experienced more depression than heterosexuals. Although the study revealed an "unmistakable, statistically significant relationship between depression and sexual orientation" (p. 133), the researcher denied that sexual orientation was an explanation for the depression.

During a community health survey at the Millennium March on Washington in 2000, the issue of depression and mental health was the number-one concern for homosexual women and the number-one concern for homosexual men after HIV/AIDS ("Depression and Mental Health," n.d.).

Eating Disorders and Standards of Attractiveness

In a nonclinical study of 250 college students—53 homosexual women, 59 homosexual men, 62 heterosexual women, and 63 heterosexual men—researchers found that the homosexual men and heterosexual women were most dissatisfied with their bodies and were vulnerable to eating disorders. They suggested that homosexual men and heterosexual women both place a high level of importance on physical attractiveness. In comparison, they found that homosexual women and heterosexual men were less concerned with their own physical attractiveness, and were therefore less dissatisfied with their bodies and less vulnerable to eating disorders (Siever, 1994).

Siever's results support the findings of earlier studies (Berscheid, Walster, & Bornstedt, 1973; Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989), and are supported by more recent studies (Ackard, Fedio, Neumark-Sztainer, & Britt, 2008; Carlat, Camargo, & Herzog, 1997).

Clinical studies of men with eating disorders found that one third were homosexual (Robinson & Holden, 1986; Schneider & Agras, 1987). In an eating disorders group, researchers confirmed that one third of the men were reportedly homosexual (Herzog, Bradburn, & Newman, 1990). Both percentages were disproportionately high compared with the percentages of homosexual men in the population.

A clinical study of men diagnosed with bulimia nervosa found that 82 percent considered themselves to be homosexual (Fichter & Hoffman, 1990).

In a nonclinical sample, after comparing heterosexual and homosexual men who were college students, researchers concluded that the homosexual men were significantly more likely to report past or current binge eating at the time of the study (Yager, Kurtzman, Landsverk, & Weismeier, 1988).

Homosexual women were found to be less invested in conventional standards of attractiveness (Brown, 1987). Instead, homosexual women placed more emphasis on physical strength as a positive physical characteristic (Striegel-Moore, Tucker, & Hsu, 1990).

Overall, homosexual men appear to have a disproportionately higher rate of eating disorders compared to heterosexual men, but homosexual women, compared with heterosexual women, do not.

Psychiatric Disorders

In a 1979 review of 53 cases of male genital self-mutilation, homosexual feelings were common in both the psychotic (87 percent) and nonpsychotic patients (Fisch, 1987).

Current sociological studies support the Fisch study, as well as the suggestive results of older, methodologically weaker studies (Ellis, 1959, 1965; Lester, 1975). In particular, the results of six independent surveys reported in the last decade are noteworthy:

- A study of Vietnam veterans (Herrell et al., 1999)
- A study of participants in the New Zealand Longitudinal Survey (Fergusson et al., 1999)
- A population-based Netherlands study (Sandfort et al., 2001)
- A separate Netherlands study (Sandfort et al., 2006)
- A U.K. Midlands survey (Meads et al., 2007)
- A survey of Massachusetts residents (Conron et al., 2008)

The Herrell et al. (1999) study of Vietnam veterans found approximately three times greater suicidality in homosexual men, a rate that was higher than would be expected even after allowing for depression and psychiatric comorbidity.

In the New Zealand study (Fergusson et al., 1999), several statistically significant odds ratios indicating the prevalence of psychological disorders in homosexuals compared with that in heterosexuals shows by what factor the occurrence was higher among homosexuals:

- depression, 4
- generalized anxiety disorder, 2.8
- conduct disorder, 3.8
- nicotine dependence, 5
- other substance abuse or addiction, 1.9
- multiple disorders, 5.9
- suicidal ideation, 5.4
- suicidal attempts, 6.2

After adjusting for other factors, the association between homosexuality and the psychological disorders remained. Followup with the same group confirmed these findings (Fergusson, Horwood, Ridder, & Beautrais, 2005).

Besides the usual hypothesis that social discrimination accounts for the association between homosexuality and increased risks for psychological disorders, Fergusson et al. (1999, 2005) propose two novel explanatory hypotheses:

- People more prone to psychiatric disorder may be more likely to become homosexual.
- Lifestyle choices by nonheterosexuals more often produce negative outcomes and mental health problems.

In their study of homosexuals in the Netherlands, Sandfort et al. (2001) found that homosexuals had statistically greater odds than heterosexuals for experiencing the following: mood disorders, 2.93; anxiety disorders among homosexual men, 2.61; and substance abuse among homosexual women, 4.05. More homosexuals than heterosexuals had two or more disorders—i.e., comorbidity—giving odds ratios of 2.70 for men and 2.09 for women. Ratios for specific disorders were:

- Bipolar: 5.02 men, 1.80 women
- Agoraphobia: 6.32 men, 1.85 women
- Obsessive-compulsive disorder (OCD): 7.18 men (women absent)

For lifetime prevalence (men and women respectively), the ratios were:

- Bipolar: 7.27, 0.92
- Panic disorder: 4.21, 0.75
- Agoraphobia: 4.54, 1.36*
- Simple phobia: 3.61, 1.27*
- OCD: 6.2, absent
- Alcohol abuse: 0.48, 2.01
- Alcohol dependence: 1.23, 3.59
- Drug abuse: 1.34, 1.88
- Drug dependence: 2.47, 8.04

** Odds ratio not significantly different statistically.*

Researchers found that the presence of HIV infection was not a significant factor affecting these prevalences and odds ratios. Overall, homosexual men showed higher levels of types of disorders that are more typical of women, and homosexual women showed higher levels of disorders more typical of men.

Using a population-based estimate of sexual orientation, Conron et al. (2008) found that among Massachusetts (U.S.) residents:

> Sexual orientation differences exist with respect to access to health care, overall health status, cancer screening, chronic health conditions, mental health, substance use including tobacco smoking, sexual health, and violence victimization. While gay/lesbian/homosexual adults evidenced poorer health and greater risk than straight/heterosexuals across several health domains, poorer health was observed most often for bisexuals. (p. 2)

King and McKeown (2003) found that two thirds of homosexual and bisexual adults in the United Kingdom are likely to have mental health problems compared to one third of heterosexuals. Warner et al. (2004) surveyed homosexual men and women in the United Kingdom; combined, 43 percent had a mental disorder as defined by the revised *Clinical Interview Schedule* (*CIS-R*). Similarly, Wang et al. (2007) found that 44 percent of the Swiss homosexual population had a *DSM-III* condition when surveyed.

Drawing from appropriate studies already referenced, Rekers (2006) shows that the lifetime prevalence of mental illness among homosexuals is 50 to 60 percent for the Netherlands and more than 70 percent for New Zealand. As Sandfort et al. (2001) report, the Netherlands has a "social climate toward homosexuality [that] has long been and remains considerably more tolerant" (p. 89). Both the Netherlands and New Zealand are known to have cultures tolerant of homosexuality and intolerant of social discrimination based on sexual orientation or sexual lifestyle.

In a study in the United States, 48 percent of homosexual men and women believed they currently needed mental health treatment, while only 22 percent of heterosexuals felt they needed treatment. Ten percent of homosexual, bisexual, and transgendered men had been hospitalized for psychopathology compared to 4.4 percent of heterosexual men. Among women, corresponding figures were 8.7 percent of homosexuals and 6.8 percent of heterosexuals (Cochran & Cauce, 2006).

Hatzenbuehler et al. (2008) found that homosexual youth under the age of 18 had 30 to 50 percent more depression and anxiety than heterosexual youth in the same age group, and that this could be entirely accounted for by emotional regulation deficits—the sexual orientation did not contribute to their model. They hypothesized that social stigma related to sexual orientation might account for emotional regulation deficits, but that this influence was indirect.

It would be difficult to find another group of people in society of comparable size to those with same-sex attraction that have such a high level of psychopathology that expresses itself in such varied forms. The case could be made that some of the most self-destructive attitudes—especially this group's willingness to engage in high-risk sex—must be related to deeper psychological issues rather than solely the person's experience of social discrimination. If social discrimination and "internalized homophobia" are solely—or primarily—to blame for the higher level of pathology, no research to date demonstrates this.

Summary of Research on Mental Health and Psychological Disorders

We think that Bailey's (1999) conclusions about the Herrell et al. (1999) and Fergusson et al. (1999) studies offer a relevant summary of the conclusions of all of the researchers investigating the relative prevalence of mental health difficulties and psychological disorders between the homosexual and heterosexual population.

> These studies contain arguably the best published data on the association between homosexuality and psychopathology, and . . . converge on the same unhappy conclusion: homosexual people are at substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder. . . . Some mental health professionals who opposed the successful 1973 referendum to remove homosexuality from DSM-III will feel vindicated. Second, some social conservatives will attribute the findings to the inevitable consequences of the choice of a homosexual lifestyle. Third, and in stark contrast to the other two positions, many people will conclude that widespread prejudice against homosexual people causes them to be unhappy, or worse, mentally ill. Commitment to any of these positions would be premature, however, and should be discouraged. It would indeed be surprising if anti-homosexual attitudes were not part of the explanation of increased suicidality among homosexual people, but this remains to be demonstrated. (p. 884)

In summary, there are now so many relevant studies that have been so carefully controlled methodologically and that have used such adequate sample sizes, the evidence is clear: *compared with the*

heterosexual population, significantly higher levels of psychological adjustment problems do exist within the homosexual population.

Interpersonal Relationships

In the case of homosexual men, homosexual relationships are considerably more unstable and less likely to be sexually monogamous than are heterosexual relationships. Many studies of homosexual men reveal this characteristic instability. The Male Couple—a study by a homosexual couple, one a psychologist and the other a psychiatrist—reported that of the 156 couples studied, only 7 maintained sexual fidelity. Those couples who had been in a relationship for more than five years were unable to maintain sexual fidelity. While the study found that close to a third of the sample lived together longer than 10 years, the author reported, "The majority of couples . . . and all the couples together longer than 5 years, were not continuously sexually exclusive with each other" (McWhirter & Mattison, 1984, p. 285).

As Kurdek and Schmitt (1986) found, while some homosexual relationships seem to last, those relationships eventually become open when a homosexual couple lives together for longer periods of time. Saghir and Robins (1973) found that 75 percent of homosexual men over the age of 40 had not experienced a relationship that lasted longer than one year. Only 8 percent of the homosexual men and 7 percent of the homosexual women ever had relationships that lasted longer than three years.

The Gay Report included findings from a study of 5,000 homosexual men and women who reported details about themselves and their relationships in both open-ended and closed-end questioning. The authors concluded that "for gay men, the process of forming a couple and staying together is by no means the same as it is for a man and a woman, married or not" (Jay & Young, 1979, p. 339). The researchers found that the average length of a homosexual relationship is about two years. Two years is also the estimate in a more recent study by Pollak (1985).

As with *The Gay Report, The Spada Report* offered survey respondents the opportunity to talk at length about their unconventional sexuality and relationships. The survey was completed by more than 1,000 homosexual men representing every state in the nation. More than half reported that they had a lover, and 74 percent of the men with lovers reported that they, their lover, or both had engaged in sex outside the relationship. One subject responded, "If anything, having sex with others [made] our love for each other stronger" (Spada, 1979, p. 190). Another reported, "Those who impose monogamy must be so terribly unsure of themselves as persons of value." He further opined that people, "sexually or otherwise, do not generate from a closed unit" (p. 190). These findings and the studies discussed above clearly show that attitudes about monogamy are very different in male homosexual relationships than in heterosexual relationships.

Harry (1984) found that while 50 percent of homosexuals report they are involved in a relationship at any given time, such involvement does not mean that they are committed or monogamous. As Henslin and Sagarin (1978) have concluded, "Many [homosexual] couples who stay together for a long time become roommates bound chiefly by companionship and domestic ties, ceasing to be bed partners and finding sex outside the relationship" (p. 229).

Researchers in Los Angeles during the late 1980s found that homosexuals averaged more than 20 partners a year (Linn et al., 1989). This number is particularly high considering the risks associated with homosexual sex. A study in Boston, also conducted during the late 1980s, found that 77 percent of more than 400 homosexual men had more than 10 partners during the five years before the study (Seage, 1992). An earlier study had found that male homosexual relationships were characteristically nonmonogamous (Blumstein & Schwartz, 1983).

Berger (1990) reported that in a sample of 92 homosexual couples, 96.4 percent described their relationship as monogamous. However, 50 percent of the couples continued to have *protected* sex with their regular partner. This implies that they were not confident of physical monogamy, and apparently assumed that there was a health risk from their partner's having sexual encounters outside of their relationship.

In their study of a nationally representative sample, Sandfort et al. (2003) concluded, "Both homosexual men and women less frequently reported having a steady partner than did heterosexual men and women" (p. 17).

More recent research suggests that even contracting a publicly professed, legally binding partnership does not prevent homosexual couples from experiencing relationship breakup more frequently than do married heterosexual couples. Andersson, Noack, Seierstad, and Weedon-Fekjaer (2006) studied 2,819 homosexuals in registered partnerships in Norway and Sweden and 222,000 opposite-sex marriages. The researchers reported that:

- *Male* homosexual registered partnerships have 1.35 times the risk of divorcing compared to heterosexual marriages.
- *Female* homosexual registered partnerships have 3.03 times the risk of divorcing compared to heterosexual marriages.
- "Divorce-risk levels are considerably higher in same-sex marriages" (p. 262).
- "The divorce risk in *female* partnerships is practically double that of the risk in partnerships of *men*" (p. 262; emphases added).

Summary of Interpersonal Relationships

Long-term male homosexual relationships are characteristically unfaithful. Even when a homosexual couple live together for a long period, the relationship eventually becomes open—in other words, nonmonogamous. Relationships between homosexual women, while tending to be more monogamous than those of homosexual men, also tend to be substantially shorter in duration than heterosexual marriages.

In summarizing a large number of studies, Whitehead and Whitehead (2007) concluded that the mean length of a relationship for homosexual couples—both male and female—is only 2.5 years. Could this relational instability be due to the unavailability of state-recognized same-sex marriage? Such a hypothesis is not supported by a study in the Nordic countries (Andersson et al., 2006), where civil unions are available, yet breakup rates of officially sanctioned homosexual partnerships are still significantly higher than in marriages between heterosexuals.

Overall, researchers comparing the longevity and frequency of interpersonal relationships between homosexual and heterosexual partners found that relationships between homosexuals are substantially less stable and more short-lived on the average compared to heterosexual relationships, notably marriages between a man and a woman. It is not unlikely that relationship instability contributes significantly to the reported greater frequency of unhappiness in homosexuals compared to heterosexuals.

Promiscuity as a New Social Norm

A stereotype of gay sexual behavior is that it is wildly promiscuous. Conversely the stereotype is that lesbians have relatively few partners, even compared to straights. A review of the literature updates suggests that neither stereotype is accurate, and that the median number of sexual partners of both homosexual men and women is approximately three to four times as many as heterosexuals men and women.

There is a convention within the male homosexual community that nonexclusive sexual relationships are normal and healthy. As Hoffman (1987) wrote, "Sexual promiscuity is one of the most striking, distinguishing features of the gay life in America" (p. 45). However, the medical and emotional risks of such behavior, including intense rage and sense of betrayal experienced by many male homosexuals who discover infidelities by their partner, suggest that while "normal" (i.e., common, typical, usual, expected), promiscuity among homosexuals is hardly healthy.

Studies throughout the 20th century note that promiscuity is a major characteristic of homosexuality. Reliable estimates of the prevalence of promiscuity among either homosexuals or heterosexuals are rarely available. For most of the literature, means or maxima are given. In mathematical terms, this is misleading—the correct statistic is the median, which is rarely calculable from the data given. However, the maxima, characteristically of thousands of lifetime partners, suggest a pathological preoccupation with the sex act, at least for a few individuals, regardless of sexual orientation.

According to Saghir and Robins (1971), homosexual men "are rarely faithful in their relationships" (p. 505). Promiscuity and multiple partnerships within the homosexual lifestyle are commonly reported (Kelly et al., 1995). Homosexual men are more inclined to have multiple sexual partners (Rotheram-Borus & Gwadz, 1993), and they have long been reported as having a higher number of sexual partners compared to heterosexual men (Bell & Weinberg, 1978). Likewise, homosexual women were found to have more female partners than a large group of heterosexual women had male partners (Goode & Haber, 1977).

John Rechy, a well-known homosexual author, reports that he has had sex with more than 7,000 men and that "thousands of sex encounters [with as many different male partners] are not rare in the gay world" (Goode & Troiden, 1980, p. 58). The results from Goode and Troiden's study reveal that "the number of partners with whom our respondents admitted having engaged in sex was, by heterosexual standards, prodigious" (p. 52). One respondent reported that he had engaged in sex with more than 10,000 men. Only 35 percent reported that they had engaged in sexual intercourse with fewer than 100 men; 42 percent reported that they had engaged in sexual intercourse with between 100 and 499 men; and 23 percent admitted to having had 500 or more partners. In contrast, the National Opinion Research Center (NORC) found that although most of the general heterosexual adult population had been having sexual intercourse since age 18, they reported only 1.2 partners during the year before the survey and only 7.2 partners since age 18 (Smith, 1991).

During the early years of the AIDS epidemic, the CDC reported that homosexual men who at that time had AIDS reported having more than 1,100 sexual partners in their lifetime (Pryor & Reeder, 1993). Critics claimed that those reports came from high-risk homosexual men and were not representative of all homosexual men. But when samples of heterosexuals with AIDS were compared with homosexuals with AIDS, the homosexuals had a median of 1,160 lifetime partners versus a median of 41 for heterosexuals (Guinan, 1984). Before AIDS came on the scene, it was reported that some homosexual men had a "scorecard" of 1,000 partners, and most had had at least 100 partners (Masters & Johnson, 1979). The Multicenter AIDS Cohort Study of nearly 5,000 homosexual men found that a significant majority of those men (69 to 83 percent) reported having 50 or more sexual partners during their lifetime (Kaslow et al., 1987).

In a study of 30 homosexual men in support groups for the sexually compulsive, researchers estimate that they had experienced an average of 2,000 different sexual encounters over their lifetime—while the heterosexuals in the support group had experienced 500 sexual encounters. Despite their awareness of AIDS, these homosexual men reported they would like to average 14 sexual experiences per month. Even after "successfully" completing the group—with the goal of reducing sexual compulsivity—these men still reported at least three different sexual partners per month. That number equaled the average

number of sexual partners of the heterosexual men when they first began the support group. Three different partners a month is still very risky given the common consequences of homosexual sex (Fluker, 1983).

According to findings of the *Journal of the International Association of Physicians and AIDS Care,* homosexual men do not always consider "monogamy" to mean a completely exclusive sexual relationship. Davies et al. (1993) reported that homosexual men averaged 70 male partners per year. By comparison, Masters and Johnson (1979) estimated that heterosexual men average 11 female partners per year.

In their study of a convenience sample that may not be representative of the U.S. population, Bell and Weinberg (1978) reported that more than 40 percent of homosexual men estimated having sex with 500 or more partners, and 28 percent had sex with 1,000 partners or more. More than 70 percent of these reported that half their partners were men with whom they had sex only once.

Probably the best U.S. population-based study on promiscuity is the National Health and Social Life Survey conducted by the NORC at the University of Chicago (Laumann et al. 1994). The study was "based on personal interviews in 1992 with 3,432 respondents who were randomly drawn from the non-institutionalized civilian population of the United States by an area probability design" (p. xxxi). Laumann et al. found a clear pattern: "In all cases, when we dichotomize our sample, the group of people with same-gender partners (or who define themselves as homosexual or bisexual) have higher average numbers of partners than the rest of the sexually active people in the sample" (p. 314).

Because of the extreme range of lifetime partners reported by some homosexuals, especially men, calculating the median (rather than the mean) average number of partners allows for a more realistic comparison between the typical number of partners of heterosexuals and homosexuals. For example, results from the National Health and Social Life Survey reveal that the average number of partners in the final year of the study was 8 for homosexuals compared to 1.2 for heterosexuals, a ratio of 7:1 (Michael et al., 1994). But the *median* numbers of lifetime partners for gays and lesbians in the United States were 2.75 and 4 times as many as for straights respectively (Laumann et al., 1994).

High promiscuity rates are common not only among American homosexuals, but are also found among homosexual men in various other countries. For example, a study of Asian and Pacific Islanders found that 95 percent of homosexual men in those cultures reported multiple same-sex sexual partners during the five years before the study (Choi, Coates, Catania, & Lew, 1995). Homosexual men in Thailand reported a higher number of total sex partners than heterosexual men in that country (Beyrer et al., 1995).

Mercer, Hart, Johnson, and Cassell (2009) conducted a national probability survey of 5,168 men in the United Kingdom from 1999–2001. The researchers found that for the preceding five years, the median numbers of partners reported by heterosexual, bisexual and exclusively homosexual men were 2, 7 and 10, respectively. Thus bisexual and exclusively homosexual men reported having 3.5 and 5 times, respectively, as many partners as the heterosexual men. This finding is reasonably consistent with best U.S. study (Laumann et al., 1994) and supports a rule-of-thumb estimate that homosexuals have approximately 3–4 times as many partners as heterosexuals.

Sexual Addiction and Coercion

Homosexual men and women report experiencing sexual addiction and are reported as being the victims and/or perpetrators of sexual molestation, rape, and other predation at rates much higher than their heterosexual counterparts. Relevant studies and findings are discussed below.

Sexual Addiction

Quadland and Shattls (1987) found that their clients reported having more sex than they wanted to have. Patients also reported feeling victimized by their frequent sexual activity in a variety of ways besides that of the obvious AIDS risk. The Pride Institute, an addiction treatment center for homosexuals, reported that sexual addiction is a severe problem in the homosexual population (Downton, 1995). Dr. Jennifer P. Schneider, an expert in the field of sexual addiction, concluded that homosexuals represent a high proportion of the sexual addiction cases (Schneider, 1991, personal communication).

Homosexual men report much greater prevalence of sexual addiction than the general population (Dodge, Reece, Cole, & Sandfort, 2004). Dodge et al. (2008) compared sexual compulsivity scores of homosexual men with those of heterosexual mean. They found higher scores for homosexual men at all venues where the homosexual men were surveyed. Dodge et al. (2008) concluded that the rate of sexual compulsivity is higher among homosexual men than their heterosexual counterparts.

Rape/Sexual Coercion

An alarming rate of sexual coercion is found in homosexual relationships. When 36 women and 34 men in homosexual relationships were asked about sexual coercion in their relationships, 12 percent of the men and 31 percent of the women reported being a victim of forced sex by their current or most recent partner (Waterman, Dawson, & Bologna, 1989).

McConaghy and Zamir (1995) found that among a group of medical students, sexual coercion against a homosexual person was significantly correlated with the coercer's homosexual orientation ($r = 0.24$, $p = 0.05$). One fourth of the men reported sexually coercing a male partner. Similarly, one fourth of the women reported sexually coercing a female partner.

A study of homosexual relationships found that 29 percent of the subjects reported being coerced into unwanted sexual contact; 92 percent of the time the coercion involved unprotected anal intercourse, increasing the already-high risk of HIV infection (Kalichman & Rompa, 1995). Similar findings were characteristic of homosexually active men in England and Wales, where 28 percent reported that they had been sexually assaulted or coerced against their will by intimate partners. Of those, 27.6 percent had been forced into same-gender anal intercourse or other sexual activity by someone with whom they had consensual sex in the past (Hickson et al., 1994).

In a study of 310 homosexual men, 15 percent reported being victims of sexual coercion (Krahé, Schütze, Fritsche, & Waizenhöfer, 2000), and a similar percentage admitted to being perpetrators. Ratner et al. (2003) reported that 14 percent of homosexual men disclosed that they had been sexually coerced before the age of 14, and 14 percent disclosed that they had been sexually coerced after the age of 14. Finally, in a recent study, 18.5 percent of homosexual men reported experiencing unwanted sexual activity (Houston & McKirnan, 2007). Comparisons with the incidence of sexual coercion among heterosexuals were not reported in any of the three studies.

Molestation

The surveyed literature concludes absolutely that the overwhelming majority of molestations of young people are committed by adults who are apparently heterosexual. Still, in relation to their numbers in the population, homosexuals may be disproportionately liable to commit such offenses, as suggested by the following paragraph, since homosexual prevalence in the population is typically only 2 to 3 percent (a percentage that includes bisexuals).

A disproportionate percentage of pedophiles are classed as homosexual in some studies: 36 percent (Freund, Heasman, Racansky, & Glancy, 1984), 35 percent (Freund & Watson, 1992), and 28 percent

(Erickson, Walbek, & Sely, 1988), depending on the study. "This suggests that the resulting proportion of true pedophiles among persons with a homosexual erotic development is greater than in persons who develop heterosexually" (Freund & Watson, 1992, p. 34). Similarly, "The frequency of homosexual contacts exceeded that of . . . other groups . . . attracted to children" (findings of Gebhard, Gagnon, Pomeroy, & Christenson, 1975, as cited in Lester, 1975, p. 82).

In a careful study comparing civilian and military rates of sexual abuse, McCarroll, Ursano, Fan, and Newby (2004) presented such detailed statistics on such large samples that pre- and post-puberty breakdowns were possible. From ages 12 to 15—post-pubertal but below the age of consent in most states—the rates per thousand (for men and women respectively) were 0.4 and 2.4. The numbers were almost identical in civilian and military populations. Assuming molestation is by homosexual and heterosexual men respectively, and if the ratio of homosexual to heterosexual in the population is taken as 3:97, a disproportionately large number of homosexual men are involved in post-pubertal molestation—about 5.3 times as many as their heterosexual counterparts.

Complicating many other studies on molestation, however, is the fact that the sexual orientation of the same-sex molester cannot always be known (as just one example, some of the men who molest same-sex children are married to women and might not be immediately identified as homosexual).

Violence

Estimates of the extent of partner violence in homosexual relationships between women vary, depending on which definition of violence is used. The various estimates include 52 percent (Lie & Gentlewainer, 1991), 25 percent (Brand & Kidd, 1986), 25 to 33 percent (Koss, 1990), two thirds (Renzetti, 1992), one in three relationships (Berry, 1994), and 31 percent (Lockhart, White, & Causby, 1994).

Studies show that homosexual women are generally more violent and criminal than heterosexual women (Ellis, Hoffman, & Burke, 1990; Owen & Burke, 2004). This held true even within prisons (Climent et al., 1977). Since violence among homosexual women is so rampant, the National Coalition Against Domestic Violence (Lobel, 1986) published the anthology *Naming the Violence: Speaking Out About Lesbian Battering,* in which several homosexual women revealed their experiences about violence among homosexual women. Describing lesbian bars, one homosexual woman was quoted as saying, "On almost every occasion that I went and stayed until closing, there was an episode of violence" (p. 11).

Brand and Kidd (1986) compared 75 self-identified heterosexual women with 55 self-identified homosexual women who were otherwise demographically similar. The study showed no significant difference between the frequencies of physical aggression in the primary relationships of the two groups. Twenty-seven percent of heterosexual women reported being abused by male partners, while 25 percent of homosexual women reported being abused by female partners. In other words, homosexual women were equally as likely to abuse their female partners as were heterosexual men.

For combined samples of men and women in a selected sample of 48 homosexual women and 50 homosexual men, 47 percent had used physically assertive tactics in their intimate relationships. Between the two groups, women tended to report fewer physically aggressive partners than did the men (Kelly & Warshafsky, 1987).

Cochran and Cauce (2006) reported that 4.4 percent of homosexual men and women entering substance abuse treatment in Washington State had suffered domestic violence in the last month, compared with 2.9 percent of heterosexuals. Lifetime figures were 55 percent for homosexuals compared with 36 percent for heterosexuals. This is one of the few studies with clear homosexual/heterosexual comparisons in the same sample.

Researchers found that the domestic violence rate of homosexual men is greater than that of heterosexual men (Seligson & Peterson, 1992). In a representative population probability sample, Greenwood et al. (2002) found that the level of violence in relationships between homosexual men was considerably higher than the level of violence by men against women in the heterosexual community. Greenwood et al. reported:

> The 5-year prevalence of physical battering among urban MSM [men having sex with men] (22.0%) was significantly higher than either the annual prevalence of severe violence (3.4%) or the annual prevalence of total violence (11.6%) among a representative sample of women who were married or cohabiting with men. (p. 1968)

Adjustment Problems for Homosexual Youth

Savin-Williams (1994) found that homosexuality in youth is associated with school problems, runaway behaviors, substance abuse, prostitution, and suicide. A number of studies substantiate these findings (Erwin, 1993; Kourany, 1987; Prenzlauer et al., 1992; Remafedi, 1987; Rich et al., 1986; Roesler & Deisher, 1972; Rotheram-Borus, Hunter, & Rosario, 1994; Saunders & Valente, 1987; Schneider et al., 1989). Homosexual and bisexual youth are at greater risk for homelessness (Kruks, 1991).

A more recent report indicates that high school students with romantic homosexual relationships have a substantially higher suicide rate than do those with heterosexual relationships. Russell and Joyner (2001) studied a nationally representative study of the general U.S. population. Their sample consisted of 5,685 adolescent boys and 6,254 adolescent girls. Same-sex romantic relationships "were reported by 1.1% of boys (n = 62) and 2.0% of girls (n = 125)" (p. 1277). The researchers found that the odds of suicidal attempts were 2.45 times higher among adolescent boys with homosexual orientation than among heterosexual boys. Similarly, the odds of suicidal attempts among adolescent girls with homosexual orientation were 2.45 times higher than among heterosexual girls.

Although some social scientists may claim that parental and peer pressures are the stressors that lead to maladaptation among homosexual adolescents, Savin-Williams (1994) concluded that such a correlation could only be called "suggestive," and acknowledged that "a causal link between these stressors and outcomes has not been scientifically established" (p. 261).

Sexuality

Scat and Water Sports

"Scat" is a name for the use of feces and defecation in sex play (i.e., *coprophilia*). "Water sports" is a colloquial expression for sexual practices tied to urination and defecation. In *The Gay Report,* 4 percent of homosexual men admitted to using defecation in sexual encounters (Jay & Young, 1979).

Fisting

"Fisting" or "handballing"—in which one man places an entire fist and even a forearm into the rectum of another—"is usually a [male] homosexual activity" (Shook, Whittle, & Rose, 1985, p. 319). Despite the severe health risks of fisting (hepatitis C transmission, emergency colostomies, bowel rupture, and even death), several homosexual or S&M organizations exist to promote it.

The annual prevalence of fisting among homosexual men is variously reported as 15 percent (Spada, 1979), 13 percent (Jay & Young, 1979), 16 percent (Crosby & Mettey, 2004), and 5 percent per year (McKusick et al., 1985). Comparatively, in the entire population it is reported as 0.5 percent per year

(Richters, Grulich, de Visser, Smith, & Rissel, 2003). Among homosexual women, the incidence of anal fisting is reported as 7 percent (Roberts, Sorensen, Patsdaughter, & Grindel, 2000) and 9 percent (Young, 1994), and vaginal fisting as 35 percent and 26 percent, respectively.

Other Unconventional Sex Practices

In *The Gay Report,* Jay and Young (1979) found that bestiality (sex with animals) was reported by 13 percent of homosexual men. Williams and Weinberg (2003) found that most participants in bestiality are bisexual or homosexual.

Conclusion

Researchers report that many differences in psychological adjustment exist between homosexual and heterosexual men and women. Recent studies confirm the results of prior decades of research demonstrating that homosexuality is associated with a significantly increased risk for mental, emotional, and behavioral disorders. Although some researchers hypothesize that social stigma against homosexuals is a possible cause of these difficulties, other researchers find that such stigma exerts only a minor contribution to their development. We believe that this conclusion will be strengthened with further research. The claim that "studies have found no differences in the psychological adjustment of lesbians and gay men from heterosexual women and men" (Rothblum, 1994, p. 214) was not accurate for its day and is also incorrect today.

Assertions of nonpathology are a distortion of the scientific literature on the subject. Such claims lie instead in the political realm and are destructive because they ultimately delay or deny treatment to those who are affected. The unavailability of timely treatment puts the medical and psychological health—not to mention the very lives—of those affected at risk.

Summary Bullets

This synthesis of the literature derived from hundreds of sources reveals that:

- Despite knowing the AIDS risk, homosexuals repeatedly and pathologically continue to indulge in unsafe sex practices.
- Homosexuals represent the highest number of STD cases.
- Many homosexual sex practices are medically dangerous, with or without protection.
- More than one third of homosexual men and women are substance abusers.
- Forty percent of homosexual adolescents report suicidal histories.
- Homosexuals are more likely than heterosexuals to have mental health concerns, such as eating disorders, personality disorders, paranoia, depression, and anxiety.
- Homosexual relationships are more violent than heterosexual relationships.
- Societal bias and discrimination do not, in and of themselves, contribute to the majority of homosexual maladaptivity.