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Same-Sex Marriage and the Schools: Potential Impact on Children via Sexuality Education

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SAME-SEX MARRIAGE AND THE SCHOOLS: POTENTIAL IMPACT ON CHILDREN VIA SEXUALITY EDUCATION

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I. INTRODUCTION

Schools exist ostensibly to educate children. Most would agree that education—the acquisition of knowledge through the learning process and the transfer of information from teacher to student—does not occur within a vacuum. Rather social, emotional and even moral development proceed along with cognitive development. Indeed, virtually every educator in the United States receives training in the cognitive development (Piaget), social/emotional development (Erikson, Goleman), and moral development of children (Kohlberg).[1] Therefore, it is reasonable to assume that what is taught influences child development in a myriad of ways not just limited to transfer of information.

A strong case can be made that sexuality education is not simply limited to the transfer of information to children but extends to other areas of development such as social/emotional and moral development. With same-sex marriage entering the public square via sexuality education and being incorporated both directly and indirectly into the education curricular, it is reasonable to assume that introducing this topic has a potential—and probable—impact on children and child development.

To fully understand the vulnerabilities of childhood and the potential impact on children of same-sex marriage via sexuality education, a brief review of cognitive, social/emotional, and moral developmental theories and applications seems essential.

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1. The following discussion of developmental theories is based on JEANNE ELLIS ORMROD, EDUCATIONAL PSYCHOLOGY (2008).

Though limited by the parameters of this presentation, the following are concise summaries to provide the context within which sexuality education—or any education— occurs. It is important to note that even though the sequence of development is somewhat predictable, children develop at different rates, and development is often characterized by spurts and plateaus with heredity and environmental factors making substantial contributions, most often interactive in their effects.

II. CHILD DEVELOPMENT THEORIES AND MODELS

A. Cognitive Development

Piaget's cognitive developmental model includes a four-stage model demarcated by years. Roughly from birth to two years old, learning is sensory in nature: children focus on what they are doing and seeing at the moment. The Pre-Operational Stage of development extends from two to ages six or seven. During this stage of cognitive development, children are restricted in how they learn and process information. Children also become egocentric in this stage, which carries with it the inability to view situations from another person's perspective. Such thinking may be illogical in many respects. The next stage of cognitive development is called the Concrete Operations Stage and extends to age eleven or twelve. This stage is characterized by more logical thinking. Children at this stage realize that others think differently than themselves. They can engage in deductive reasoning and are able to draw logical inferences from two or more pieces of information. The final Piagetian stage of cognitive development is called the Formal Operations Stage and extends through adulthood. This stage is characterized by the ability to reason about abstract, hypothetical ideas.[2]

B. Social and Emotional Development

Erik Erickson's social/emotional development model extends throughout the life span of a person and is characterized by certain developmental tasks beginning with the Trust versus Mistrust of infancy where the child's basic

2. *Id.* at 29–42.

needs are met, where children learn to trust the affection and comfort of caregivers through constancy. Following the Trust versus Mistrust stage, the Autonomy versus Shame stage emerges. This stage includes the toddler years and is characterized by children becoming more self-sufficient in meeting their own needs and the development of a sense of handling things on their own. If not allowed to complete tasks on their own, no matter how imperfectly done, or if ridiculed for their efforts, children may develop a sense of shame and doubt. The developmental task of the next stage, which occurs during the pre-school years, is Initiative versus Guilt. During this stage, children learn to make realistic and appropriate choices and there is a focus on initiative in planning and undertaking activities. Children can develop guilt if parents discourage the pursuit of independent activities or dismiss efforts as silly or bothersome. According to Erickson, the elementary school years are characterized by Industry versus Inferiority. During this stage, children develop self-confidence through the performance of activities that gain them recognition. Such activities may include drawing pictures, solving problems and writing sentences. If children are ridiculed or punished for their efforts, often feelings of inferiority will develop. The next stage of development occurs during adolescence and is characterized by Identity versus Role Confusion. This is the transitional stage from childhood to adulthood. With mixed ideas and feelings about how they fit into society, adolescents often experiment with ideas ranging from sexuality to religion to politics. Most adolescents are able to achieve some sense of identity about who they are and where their lives are headed. The next three stages are adult stages of development. Young adults experience Intimacy versus Isolation where they are capable of forming lasting friendships and getting married. When such relationships are not formed, feelings of isolation often result. Middle age is characterized by Generativity versus Stagnation, which includes a focus on satisfaction and contributions to society. The final Erickson stage, encompassing the retirement years, is Integrity versus Despair.[3]

3. *Id.* at 73.

C. Moral Development

Moral Development proceeds along a similar path to both cognitive and social/emotional development. Children's beliefs about moral and immoral behavior are central to Lawrence Kohlberg's theory of moral development. Kohlberg's theory has three levels with each level divided into two stages. The Preconventional Level of Morality is characterized by the lack of internal standards of what is right and wrong; decision-making is based on what is in the best interest of one's self. This level of morality is most often observed in preschool and elementary school children but may be observed in some junior high and even high school students. The two stages in this level of moral development suggest that what is moral and what is not is based upon punishment/avoidance and obedience as well as the exchange of favors—with the "what's in it for me" notion. Right and wrong is determined by personal consequences. The next Kohlberg level is Conventional Morality and typically does not appear until high school. This level is characterized by an uncritical acceptance of society's conventions regarding right and wrong. During this level of development, adolescents make decisions based on what will please others (good boy/good girl stage) and look to society as a whole for guidelines about what is right and wrong (law and order). Level three is labeled Postconventional Morality and is rarely seen before college. Right and wrong emerges from self development and focuses on abstract principles to determine what is right and what is wrong. This level is divided into two stages: social contract (rules are seen as mechanisms to maintain general societal order and to protect individual rights) and universal ethical principle, which focuses on the equality of all people and a focus on human dignity and a commitment for justice.[4]

It is within the context of these developmental processes that sexuality education has its influence and potential impact, which accounts for the controversy over what should be taught when, and by whom. As same-sex marriage enters the classroom, so does human sexuality, which includes homosexuality and homosexual relationships. It is important to know what science can and cannot say about homosexuality.

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4. *Id.* at 95–98.

III. IDEOLOGY V. SCIENCE: WHAT SCIENCE CAN AND CANNOT SAY ABOUT HOMOSEXUALITY AND HOMOSEXUAL RELATIONSHIPS

What should be central to sexuality education—or any education for that matter—is what science can and cannot say. Particularly when discussing human sexuality with children, whose vulnerabilities are dependent upon the developmental processes, educators and parents should be fully apprised of what science can and cannot say. Any discussion of same-sex marriage, homosexuality, and homosexual relationships should be supported by scientific data, even and especially if that data is inconclusive or controversial.

A. Current State of Scientific Knowledge Regarding the Genesis of Homosexuality

1. Is homosexuality innate?

Homosexuality is not simply a product of biology. There is no gene that makes one homosexual. The primary researchers whose studies have been used to support the notion of a gay gene have all admitted that their research far from proves that homosexuality is simply a matter of biology. LeVay, Bailey and Pillard as well as Hamer have all clearly stated that their studies do not prove that homosexuality emerges from biology alone.[5] The independent research teams of Byne and Parsons, as well as Friedman and Downey, subsequently to reviewing the research, all conclude that homosexuality is not simply a matter of biology.[6] In fact Friedman and Downey state:

> At clinical conferences one often heard . . . discussants commenting that 'homosexuality is genetic,' and therefore, that homosexual orientation is fixed and unmodifiable. Neither assertion is true . . . . The assertion that

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5. J. Michael Bailey et al., *Genetic and Environmental Influences on Sexual Orientation and Its Correlates in an Australian Twin Sample*, 78 J. PERSONALITY & SOC. PSYCHOL. 524, 533–34 (2000); David Nimmons, *Sex and the Brain*, DISCOVER, Mar. 1994, at 66 (citing Simon LeVay), *available at* http://discovermagazine.com/1994/mar/sexandthebrain346.

6. William Byne & Bruce Parsons, *Human Sexual Orientation: The Biologic Theories Reappraised*, 50 ARCHIVES GEN. PSYCHIATRY 228 (1993); Richard C. Friedman & Jennifer I. Downey, *Neurobiology and Sexual Orientation: Current Relationships*, 5 J. NEUROPSYCHIATRY & CLINICAL NEUROSCI. 131 (1993).

> homosexuality is genetic is so reductionist that it must be dismissed out of hand as a general principle of psychology.[7]

LeVay's conclusion is representative of the biologic theory of homosexuality. He summarized his research results in the following way: "It's important to stress what I didn't find . . . . I did not prove that homosexuality is genetic, or find a genetic cause for being gay. I didn't show that gay men are 'born that way,' the most common mistake people make in interpreting my work."[8]

Even the American Psychological Association (APA) changed its position in 2008 to reflect research findings. The 1998 APA statement read, "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality."[9] The 2008 APA statement reads,

> There is no consensus among scientists about the exact reasons . . . . Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or set of factors. Many think that nature and nurture both play complex roles.[10]

Perhaps the most succinct summary of the research on the genetics and homosexuality comes from Dr. Francis S. Collins, the former director of the National Human Genome Research Institute and the current director of the National Institutes of Health. He offered the following:

> An area of particular strong public interest is the genetic basis of homosexuality. Evidence from twin studies does in fact support the conclusion that heritable factors play a role in male homosexuality. However, the likelihood that the identical twin of a homosexual male will also be gay is about 20 percent (compared to 2–3 percent of males in the general

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7. RICHARD C. FRIEDMAN & JENNIFER I. DOWNEY, SEXUAL ORIENTATION AND PSYCHOANALYSIS: SEXUAL SCIENCE AND CLINICAL PRACTICE 39 (2002).

8. Nimmons, *supra* note 5, at 66.

9. *Answers to Your Questions about Sexual Orientation and Homosexuality* (Am. Psychol. Ass'n, Washington, D.C.) 1998, at 1.

10. *Answers to Your Questions for a Better Understanding of Sexual Orientation and Homosexuality* (Am. Psychol. Ass'n, Washington, D.C.), 2008, at 2, *available at* http://www.apa.org/topics/sexuality/sorientation.pdf.

> population), indicating that sexual orientation is genetically influenced but not hardwired by DNA, and that whatever genes are involved represent predispositions, not predeterminations.[11]

Simply stated, if homosexuality were completely genetic, if one identical twin was homosexual, then the other would be homosexual. But that is not the case. Most complex behavior traits are polygenic and multifactorial. And homosexuality is no different.[12]

Psychological science offers various theories regarding the etiology of homosexuality from the psychoanalytical and social learning theories to the interactional theories. Each framework has made contributions to understanding possible routes to the development of homosexual attraction, and there is some psychological scientific evidence to support each. From the psychoanalytical perspective, homosexuality emerges from a context of difficult family relationships, particularly a disconnected father and an over-involved mother. These unhealthy relationships contribute to the rejection of a masculine or feminine gender identity.[13] Social learning theory explains how individuals learn through observations and adopt actions and attitudes from significant others.[14] This theory maintains that behavioral conditioning, both direct and indirect, accounts for attractions we develop and the behaviors we adopt. From this perspective, children and adolescents learn about sexual behavior and sexual preference from parents, peers and the media. They get rewarded or punished by significant others for their sexual attitudes and behaviors. Social learning theory can account for the role of serious trauma, such as sexual abuse, in the development of homosexual behavior. Some researchers have observed a higher prevalence of sexual abuse in the histories of both male and female homosexuals. For example, Shrier and Johnson found that boys who were sexually abused were seven times

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11. FRANCIS S. COLLINS, THE LANGUAGE OF GOD 260 (2006).

12. *Id.* at 257–63.

13. JOSEPH NICOLOSI, REPARATIVE THERAPY OF MALE HOMOSEXUALITY 28 (1991); George A. Rekers, *The Formation of a Homosexual Orientation*, *in* HOPE FOR HOMOSEXUALITY 1, 4 (Patrick F. Fagan ed., 1988); Irving Bieber, *A Discussion of* Homosexuality: The Ethical Challenge, 44 J. CONSULTING & CLINICAL PSYCHOL. 157, 163 (1976).

14. ALBERT BANDURA, SOCIAL LEARNING THEORY (1977); ALBERT BANDURA & RICHARD H. WALTERS, SOCIAL LEARNING & PERSONALITY DEVELOPMENT (1963).

more likely to self-identify as homosexual or bisexual.[15] Friedman and Downey concluded that boys who later identified as homosexual had become sexually active at an earlier age than did their heterosexual counterparts.[16] Using a nonclinical population, Tomeo, Templer, Anderson, and Kotler noted that 46% of gay men and 22% of lesbians were sexually abused as children, compared to 7% of the matched heterosexual men and 1% of the matched heterosexual women.[17] Steed and Templer, in their study of the impact of molestation on sexual orientation, concluded that "homosexually molested participants were more likely to say that the molestation had an impact on their sexual orientation than heterosexually molested participants."[18] There is evidence to support the role of peers in the development of homosexual attractions as well. Research suggests that the lack of connection with same-sex peers sets the stage for later development of homosexual attractions. Young men experiencing peer neglect or peer abuse, such as teasing and bullying, often feel disconnected from their own masculinity. Such trauma, particularly during the early preadolescent years, can cause gender confusion. More recently, support for the contributions of peer abuse to the development of homosexuality has emerged from the work of Pennsylvania psychiatrist Richard Fitzgibbons.[19]

Interactional theory combines the indirect or predisposing effects of biology with environmental factors to explain homosexuality. Daryl C. Bem, a self-identified gay researcher at Cornell University, postulates that genes do not directly cause homosexuality, but rather they set the stage for

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15. Diane Shrier & Robert L Johnson, *Sexual Victimization of Boys: An Ongoing Study of an Adolescent Medicine Clinic Population*, 80 J. NAT'L MED. ASSOC. 1189, 1190–93 (1988).

16. Richard C. Friedman & Jennifer I. Downey, *Homosexuality*, 331 NEW ENG. J. MED. 923, 923–24 (1994).

17. Marie E. Tomeo et al., *Comparative Data of Childhood and Adolescent Molestation in Heterosexual and Homosexual Persons*, 30 ARCHIVES SEXUAL BEHAV. 535, 539 (2001).

18. Jessica Jones Steed & Donald I. Templer, *Gay Men and Lesbian Women with Molestation History: Impact on Sexual Orientation and Experience of Pleasure*, 3 OPEN PSYCHOL. J. 36, 36 (2010), *available at* http://www.benthamscience.com/open/topsyj/articles/V003/36TOPSYJ.pdf.

19. Richard Fitzgibbons, *The Origins and Therapy of Same-Sex Attraction Disorder*, *in* HOMOSEXUALITY AND AMERICAN PUBLIC LIFE 85 (Christopher Wolfe ed., 1999).

homosexuality by influencing temperament.[20] His theory, known as "Exotic Becomes Erotic," suggests that when temperament is associated with gender non-conformity—where boys identify with girls and girls with boys in terms of their activities—the child is prevented from interacting with same-sex peers and thus fails to bond or identify with same-sex peers. During adolescence, these young people sexualize "otherness," or those with whom they are not identified. In other words, these preadolescents sexualize that with which they are not familiar. Bem's research is supportive of a developmental trajectory where boys, in particular, see themselves as different from their male peers, and this difference becomes sexualized, later leading to the development of homosexual attractions. This interactional theory seems a logical alternative to the biological, psychoanalytical and social learning theories. The interactional theory postulates that biologically predisposed personality or temperamental traits are nurtured in relationships and environmental contexts. Thus, this model accounts for a variety of factors, or what some have labeled the "conspiracy of factors," that later combines to shape homosexual attractions and homosexual behaviors. However, the primary drawback is the failure of interactional theory to consider the role of agency or choice in the development of homosexuality.

2. Agency and homosexual behavior: a neglected area

Biological theory suggests the force of nature, found in genes and prenatal hormones, influence the development of homosexual attractions and behavior. In addition, environmental theory suggests the influence of family and peer relationships, as well as the importance of modeling and the media, in said development. Further, the interactional model posits some contribution from each in the cultivation of homosexual attractions and behavior. However, these theories leave one essential question unanswered: what is the role of agency, choice, or the person's own participation in the development of sexual preference?

Choice does not necessarily mean conscious choice. Sexual attractions may not be chosen, but responses to those

20. Daryl J. Bem, *Exotic Becomes Erotic: A Developmental Theory of Sexual Orientation*, 103 PSYCHOL. REV. 320, 331 (1996).

attractions do involve choice. Unbidden attractions may come because of situational factors and prior sexual experiences. There may even be some kind of biological predisposition that make such attractions more probable than not. But these attractions may be increased or decreased by the choices that people make.

Byne and Parsons make this argument: "Conspicuously absent from most theorizing on the origins of sexual orientation is an active role of the individual in constructing his or her own [sexual] identity."[21] Diamond, as well, noted that while biology may predispose a person's sexual orientation, an individual is flexible in responding to such biological predispositions and environmental influences.[22] Perhaps the lesbian activist Camille Paglia said it best when she concluded, "There is an element of choice in all behavior, sexual or otherwise."[23]

3. A biopsychosocial model mediated by agency best fits the scientific data

A biopsychosocial model mediated by choice best represents the current state of the research on homosexuality. Homosexuality is not explained by either a simple biological model or a simple psychological model, nor can homosexuality be reduced to a simple matter of choice. Emerging scientific evidence supports the notion that homosexuality is not easily or simply defined and that homosexuals are not a homogeneous population. In addition, the terms "homosexual attraction," "homosexual orientation," and "homosexual identity" refer to distinctly different phenomena. Homosexual attractions may emerge during adolescence and disappear. In fact, in one study, nearly 26% of twelve-year-olds reported being unsure about their sexual orientation.[24] However, only 2–3% will self-identify as gay as adults.[25] A homosexual orientation, which is a general affective response to members of one's own sex, appears to be fluid—it may wax or wane. A homosexual identity is a sociopolitical statement that one wishes to be gay

21. Byne & Parsons, *supra* note 6, at 236.

22. *See* LISA M. DIAMOND, SEXUAL FLUIDITY: UNDERSTANDING WOMEN'S LOVE AND DESIRE 63–64 (2008).

23. CAMILLE PAGLIA, TRAMPS AND VAMPS 90 (1994).

24. Gary Remafedi et al., *Demography of Sexual Orientation in Adolescents*, 89 PEDIATRICS 714, 720 (1992).

25. *Id.*

identified. Frequently, the three distinct categories are merged in both the media and academia, making it even difficult to discuss the term homosexuality.

Perhaps the more important questions are as follows: What can scientists say about the malleability of homosexuality? Once established, are homosexual attractions modifiable or changeable? Or, can an individual who is predominantly homosexual become predominantly heterosexual?

B. Current State of the Scientific Knowledge about Homosexuality: Immutable?

The history of providing psychological care for those distressed by unwanted homosexuality demonstrates that homosexuality is not invariably fixed in all people with homosexual attractions. Prior to 1973, when lobbying by gay activists led to the removal of homosexuality from the psychiatric manual, psychological care was routinely provided to those who were distressed by their unwanted homosexual attractions.[26] In reviewing the research prior to this time, Satinover reported a composite success rate of 50%.[27] Masters and Johnson reported a success rate of 65% after a five-year follow-up.[28] James conducted an analysis of over a hundred studies and reported that 35% of those with homosexual attractions "recovered," and an additional 27% "improved." She concluded that significant improvement and even complete recovery from a homosexual orientation was entirely possible.[29] More than thirty years ago, Freund, using penile plethysmography, found that some homosexual men could voluntarily alter their penile responses to heterosexual stimuli without ever receiving reorientation therapy.[30] More recently, Lisa Diamond concluded that sexual identity is far from fixed

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26. RONALD BAYER, HOMOSEXUALITY AND AMERICAN PSYCHIATRY: THE POLITICS OF DIAGNOSIS 39–40, 194 (1981).

27. JEFFREY S. SATINOVER, HOMOSEXUALITY AND THE POLITICS OF TRUTH 186 (1996).

28. Mark F. Schwartz & William H. Masters, *The Masters and Johnson Treatment for Dissatisfied Homosexual Men*, 141 AM. J. PSYCHIATRY 173, 173 (1984).

29. Elizabeth James, Treatment of Homosexuality: A Reanalysis and Synthesis of Outcome Studies (1978) (unpublished Ph.D. dissertation, Brigham Young University) (on file with Brigham Young University Library).

30. Kurt Freund, *A Laboratory Method of Diagnosing Predominance of Homo- or Hetero-Erotic Interest in the Male*, 31 BEHAV. RES. & THERAPY 85, 85–93 (1963).

in women who are not exclusively heterosexual.[31] Although Diamond does not want her study to be used to support the notion of fluidity of homosexual attractions, her longitudinal research does just that.[32] In addition, researcher Ellen Schecter conducted in-depth research for ten years with women who self-identified as lesbians and were currently living in heterosexual relationships for at least one year. She concluded that labels such as lesbian may oversimplify women's sexual identity and experience.[33]

Other psychological studies, including a national survey[34] and a meta-analysis,[35] support the notion of malleability of homosexual attractions, yielding a singular conclusion: homosexuality is more fluid than fixed, and psychological care for those distressed by unwanted homosexual attractions is indeed successful for some individuals.

Perhaps one of the more significant studies conducted in recent years which supports the malleability of homosexuality was that conducted by Dr. Robert L. Spitzer, who was, ironically, the same psychiatrist who led the charge to remove homosexuality from the psychiatrist manual in 1973. From his study of 200 individuals, Spitzer found that 66% of the men and 44% of the women had achieved good heterosexual functioning. Subsequent to therapy, 89% of the men and 95% of the women reported that they were bothered slightly or not at all by unwanted homosexual attractions. Spitzer concluded, contrary to the assertions by some, that therapy was not harmful. In fact, many of the participants in his study were depressed when they began psychological care; however, none were depressed at the termination of care. Further, Spitzer concluded that the changes were made not just in attraction and behavior but rather in core features of sexual orientation such as fantasy and arousal.[36] Spitzer summarized his

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31. Lisa M. Diamond, *Sexual Identity, Attractions, and Behavior among Young Sexual Minority Women over a 2-Year Period*, 36 DEVELOPMENTAL PSYCHOL. 241, 241 (2000).

32. *See* DIAMOND, *supra* note 22, at 63–64.

33. Mark Greer, *Labels May Oversimplify Women's Sexual Identity, Experiences*, 35 MONITOR ON PSYCHOL. 28 (2004).

34. Joseph Nicolosi et al., *Retrospective Self-Report of Changes in Homosexual Orientation: A Consumer Survey of Conversion Clients*, 86 PSYCHOL. REP. 1071 (2000).

35. A. Dean Byrd et al., *A Meta-Analytic Review of Treatment of Homosexuality*, 90 PSYCHOL. REP. 1139 (2002).

36. Robert L. Spitzer, *Can Some Gay Men and Lesbians Change Their Sexual*

findings: "Like most psychiatrists, I thought that homosexual behavior could not be resisted, and that no one could really change their [sic] sexual orientation. I now believe that to be false. Some people can and do change."[37] Additional analysis of the Spitzer research was conducted by the essentialist Scott Hershberger who provided further support to Spitzer's research. Hershberger concluded that Spitzer's research provided good scientific evidence that psychological care could assist individuals in changing their homosexual orientation to a heterosexual orientation.[38]

Other peer-reviewed research conducted by Karten[39] as well as Yarhouse and Jones[40] offered additional scientific support for the malleability of homosexuality. The longitudinal study by Yarhouse and Jones found empirical evidence that change of homosexual orientation was possible through religious ministries.[41]

C. Current Scientific Knowledge about Homosexual Relationships

Homosexual relationships differ from heterosexual relationships in major ways: levels of promiscuity, physical and mental health, and monogamy.

1. Levels of promiscuity

Homosexual relationships are less permanent, and its participants are less monogamous. Perhaps the most extensive study on sexual monogamy ever done was completed by Robert Michael et al. in 1994.[42] These researchers found that the vast majority of heterosexual couples were monogamous while the

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Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation, 32 ARCHIVES SEXUAL BEHAV. 403, 413 (2003).

37. Press Release, NARTH, Prominent Psychiatrist Announces New Study Results: Some Gays Can Change (updated version Sept. 3, 2008), *available at* http://narth/docs/spitzer2.html.

38. Scott L. Hershberger, *Guttman Scalability Confirms the Effectiveness of Reparative Therapy*, 32 ARCHIVES SEXUAL BEHAV. 440, 440 (2003).

39. Elan Y. Karten & Jay Wade, *Sexual Orientation Change Efforts in Men: A Client Perspective*, 18 J. MEN'S STUDIES 84 (2010).

40. STANTON L. JONES & MARK A. YARHOUSE, EX-GAYS: A LONGITUDINAL STUDY OF RELIGIOUSLY MEDIATED CHANGE IN SEXUAL ORIENTATION (2007).

41. *Id.*

42. ROBERT T. MICHAEL ET AL., SEX IN AMERICA: A DEFINITIVE SURVEY 101 (1994).

marriage was intact.[43] Their research showed that 94% of married couples and 75% of cohabiting couples had only one partner in the previous twelve months.[44] An extensive study on homosexuality and monogamy was published in 1984 by David McWhirter and Andrew Mattison.[45] The Male Couple Study was designed to evaluate the quality and stability of long-term male homosexual couplings.[46] The study was actually undertaken to disprove the reputation that gay male relationships do not last.[47] After much searching, these researchers were able to locate 156 couples who had been in relationships that lasted from one to thirty-seven years.[48] Two-thirds of the respondents in the study had entered the relationship with either the implicit or explicit expectation of sexual fidelity.[49] The researchers found that of the 156 couples, only seven had been able to maintain sexual fidelity.[50] Furthermore, none of the seven couples had been together for more than five years.[51] In other words, these researchers were unable to find a single male couple who had been able to maintain sexual fidelity for more than five years.[52]

Dr. Colleen Hoff, author of the Gay Couple Study, which followed 556 male couples for three years, reported that about 50% of those surveyed had sex outside their relationships with the full knowledge and approval of their partners.[53] Prior to the AIDS epidemic, Bell and Weinberg reported that 28% of homosexual men had more than 1,000 lifetime partners.[54] Michael et al. reported a comparative statement: "It is extremely rare for a heterosexual who is not a prostitute to have 1,100 lifetime sexual partners, as the average gay man

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43. *Id.* at 89.

44. *Id.* at 102.

45. DAVID P. MCWHIRTER & ANDREW M. MATTISON, THE MALE COUPLE: HOW RELATIONSHIPS DEVELOP (1984).

46. *Id.* at 2.

47. *Id.*

48. *Id.* at ix.

49. *Id.* at 252.

50. *Id.*

51. *Id.*

52. *Id.*

53. Scott James, *Many Successful Gay Marriages Share an Open Secret*, N.Y. TIMES, Jan. 29, 2010, at 17A.

54. ALAN P. BELL & MARTIN S. WEINBERG, HOMOSEXUALITIES: A STUDY OF DIVERSITY AMONG MEN AND WOMEN 308 (1978).

infected with HIV had in the beginning of the epidemic."[55] The Centers for Disease Control (CDC) reported that between 1994 and 1997, the percentage of gay men reporting multiple partners increased from 23.6% to 33.3%, with the largest increase in men under twenty-five years of age.[56] Maria Xiridou et al. found that homosexual married couples had an average of eight partners per year outside their relationship. The study was conducted at the Amsterdam Municipal Health Service. In the Netherlands, homosexual marriage has been legal since 2001.

Gabriel Rotello, a gay author, noted, "Gay liberation was founded . . . on a sexual brotherhood of promiscuity and any abandonment of that promiscuity would amount to a communal betrayal of gargantuan proportions."[57] Bailey offered the following explanation: "Gay men who are promiscuous are expressing an essentially masculine trait. They are doing what most heterosexual men would do if they could. They are in this way just like heterosexual men, except they don't have women to constrain them."[58] Bailey later commented:

> Regardless of marital laws and policies, there will always be fewer gay men who are romantically attached. Gay men will always have many more sexual partners than straight people do. Those who are attached will be less sexually monogamous. And although some gay male relationships will be for life, these will be fewer than among heterosexual couples . . . . The relative short duration, the sexual infidelity—are indeed destructive in a heterosexual context, but they are unlikely to ever comprise a substantial proportion of gay men.[59]

While promiscuity among lesbians is less extreme, an Australian study revealed that lesbians were four and a half times more likely to have more than fifty lifetime male partners than heterosexual women, demonstrating not only the lack of stability in lesbian relationships but the bisexually behaving nature of those relationships.[60]

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55. MICHAEL ET AL., *supra* note 12, at 214.

56. Centers for Disease Control, *Increases in Unsafe Sex and Rectal Gonorrhea among Men Who Have Sex with Men—San Francisco, California, 1994–1997*, 48 MORBIDITY & MORTALITY WKLY. REP. 45, 46 (1999).

57. GABRIEL ROTELLO, SEXUAL ECOLOGY: AIDS AND THE DESTINY OF GAY 112 (1997).

58. J. MICHAEL BAILEY, THE MAN WHO WOULD BE QUEEN 87 (2003).

59. *Id.* at 100.

60. Katherine Fethers & Caron Marks et al., *Sexually Transmitted Infections and*

2. Homosexual practices and physical health

Both heterosexuals and homosexuals engage in sexual behaviors that place them at risk for medical disease. However, both medical and social sciences support the conclusion that male homosexual behaviors inherently place participants at risk for disease. A British medical scientist summarizes the data:

> Male homosexual behaviour is not simply active or passive, since penile-anal, mouth-penile, and hand-anal contact is usual for both partners, and mouth-anal contact is not infrequent . . . . Mouth-anal contact is the reason for the relatively high incidence of disease caused by bowel pathogens in male homosexuals. Trauma may encourage the entry of micro-organisms and thus lead to primary syphilitic lesions occurring in the anogenital area . . . . In addition to sodomy, trauma may be caused by foreign bodies, including stimulators of various kinds, penile adornments, and prostheses.[61]

Human physiology does not accommodate anal intercourse without significant medical risks to its participants. The rectum significantly differs from the vagina in its suitability for penetration. The repeated trauma that results from anal intercourse may lead to the leakage of fecal material that can lead to chronic disease. While the vagina has natural lubricants and is supported by a network of muscles, the anus has no such protection. Furthermore, ejaculate has immunosuppressive qualities that have been demonstrated in animal studies. Semen present in the anus may have a similar effect. Male anal intercourse is a most efficient way of transmitting HIV and other infections. The list of diseases associated with anal intercourse in homosexual men is alarming and include anal cancer, HIV, viral hepatitis types B & C, human papillomavirus, Giardia lamblia, Isospora belli and microsporidia as well as syphilis and gonorrhea. Sexual transmission of some of these diseases is so infrequent in the exclusively heterosexual population as to be virtually unknown. Other homosexual practices, such as fisting, which

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Risk Behaviours in Women Who Have Sex with Women, 76(5) SEXUALLY TRANSMITTED INFECTIONS 345, 347 (2000).

61. R. R. Wilcox, *Sexually Behaviour and Sexually Transmitted Disease Patterns in Male Homosexuals*, 57 BRIT. J. VENEREAL DISEASES 167, 167 (1981).

refers to the insertion of a hand or forearm into the rectum, are far more damaging than anal intercourse. One researcher found that 22% of homosexuals engaged in fisting.[62] Although the health consequences of lesbian practices are less well documented, there is an overrepresentation of certain medical conditions in the lesbian population including bacterial vaginosis, Hepatitis B, Hepatitis C, heavy cigarette smoking, alcohol use, and intravenous drug use. In one study of women who had sex with only women in the previous twelve months, 30% had bacterial vaginosis, which is associated with a higher risk for pelvic inflammatory disease and other sexually transmitted infections.[63] The June 2003 issue of the *American Journal of Public Health* was devoted to the health risks associated with homosexual practices. The journal's editor summarized the journal's research reports: "Having struggled to come to terms with the catastrophic HIV epidemic among [men who have sex with men (MSM)] in the 1980s . . . are we set to backslide a mere 20 years later as HIV incidence rates move steadily upward, especially among MSM?"[64]

Research evidence has consistently demonstrated that those who practice homosexuality are more at risk for some forms of mental illness such as anxiety, depression, suicidality and multiple disorders. In the *Archives of General Psychiatry*, researchers arrived at the following conclusions: "Same-gender sexual orientation is significantly associated with each of the suicidality measures . . . . The substantial increased lifetime risk of suicidal behaviors in homosexual men is unlikely due to substance abuse or other psychiatric co-morbidity."[65] In other words, suicidality is associated with homosexual orientation and not some other co-existing condition like substance abuse or depression. In the same journal, Ferguson et al. reached the following conclusion: "Gay, lesbian and bisexual young people were at increased risks of major depression . . . generalized anxiety disorder . . . conduct disorder . . . nicotine

62. JOHN R. DIGGS, JR., THE HEALTH RISKS OF GAY SEX 5 (2002) (citing KARLA JAY & ALLEN YOUNG, THE GAY REPORT: LESBIANS AND GAY MEN SPEAK OUT ABOUT SEXUAL EXPERIENCES AND LIFESTYLES 554–55 (1979)), *available at* http://www.corporate resourcecouncil.org/white_papers/Health_Risks.pdf.

63. *Id.* at 6.

64. Mary E. Northridge, *HIV Returns*, 93 AM. J. PUB. HEALTH 860, 860 (2003).

65. R. Herrell et al., *Sexual Orientation and Suicidality: A Co-Twin Control in Adult Men*, 56 ARCHIVES GEN. PSYCHIATRY 867, 867 (1999).

dependence . . . multiple disorders . . . suicidal ideation . . . suicide attempts."[66] Commentaries were offered in the same journal by J. Michael Bailey, Gary Remafedi and Richard Friedman. All three concluded that there was little doubt that a strong association existed between homosexual practices and mental illness.[67] Bailey offered the following hypotheses for consideration:

- The increased depression and suicidality among homosexual individuals are consequential to society's negative view of this group.
- Because homosexuality represents a deviation from normal heterosexual development, it represents a developmental error, rendering homosexual individuals vulnerable to mental illness.
- The increased psychopathologies in homosexual people is a lifestyle consequence such as the risk factors associated with receptive anal sex and promiscuity.[68]

Bailey's first hypothesis is quite unlikely because the study was replicated in the Netherlands, arguably the most gay-affirming society in the world, and had similar but more robust results. The researchers, Sandfort et al., summarized the results of this replicated study conducted in the Netherlands:

> Psychiatric disorders were more prevalent among homosexually active people compared with heterosexually active people. Homosexual men had a higher prevalence of mood disorders . . . than heterosexual men. Homosexual women had a higher prevalence of substance abuse disorders than heterosexual women . . . . The findings support the conclusion that people with same-sex behavior are at greater risk for psychiatric disorders.[69]

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66. David M. Ferguson et al., *Is Sexual Orientation Related to Mental Health Problems and Suicidality in Young People?*, 56 ARCHIVES GEN. PSYCHIATRY 876, 876 (1999).

67. J. Michael Bailey, *Homosexuality and Mental Illness*, 56 ARCHIVES GEN. PSYCHIATRY 883, 883–84 (1999); Richard C. Friedman (1999), *Homosexuality, Psychopathology, and Suicidality*, 56 ARCHIVES GEN. PSYCHIATRY 887, 887–88 (1999); Gary Remafedi, *Suicide and Sexual Orientation: Nearing the End of Controversy?*, 56 ARCHIVES GEN. PSYCHIATRY 885, 885–86 (1999).

68. Bailey, *supra* note 67, at 884.

69. T.G. Sandfort et al., *Same-Sex Behavior and Psychiatric Disorders: Finding from Netherlands Mental Health Survey and Incidence Study*, 58 ARCHIVES GEN.

IV. SAME-SEX MARRIAGE, HOMOSEXUALITY, HOMOSEXUAL PRACTICES, HUMAN SEXUALITY, HUMAN PHYSIOLOGY, SEXUALITY EDUCATION AND CHILDREN

Like education generally, sexuality education does not occur within a vacuum. Children learn and process information in the context of their development, specifically in the context of their cognitive, social/emotional, and moral readiness. Sexuality education influences their development and their development influences how sexuality education is processed.

Because same-sex marriage is inseparably connected to homosexuality and homosexual relationships, sexuality education should be informed by what science can and cannot say about human sexuality—especially homosexuality—and human physiology. This is particularly the case with children, whose very lives may be influenced by what they are taught.

A review of the *Guidelines for Comprehensive Sexuality Education* (2004) includes the following in its Background and Introduction sections:

> The Sexuality Information and Education Council (SIECUS) believes that all people have the right to comprehensive sexuality education that addresses the socio-cultural, biological, psychological and spiritual dimensions of sexuality by providing information, exploring feelings, values, and attitudes; and developing communication, decision-making, and critical-thinking skills.[70]

Since these guidelines were first developed more than ten years ago, they are probably the single most influential publication used by educators to implement sexuality education into the school curricula either formally or informally through the insertion into existing courses such as biology or social science.

While there is much in this mission statement to be admired and valued, information contained in any resulting guidelines should be tied to what science can and cannot say about human sexuality, particularly homosexuality. A review of the Guidelines demonstrates that there is little to be found

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PSYCHIATRY 85, 85 (2001).

70. INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES, GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION 13 (3d ed. 2004) [hereinafter GUIDELINES], *available at* http://www.siecus.org/_data/global/images/guidelines.pdf.

in the way of the required science noted above. No mention is made of any of the studies noted in the first part of this paper. While it is beyond the scope of this paper to offer a full critique of the Guidelines even in regards to homosexuality, homosexual activities and homosexual relationships, it seems appropriate to cite omissions (what science was omitted), commissions (information for where the science is absent), and distortions (where science was misrepresented) in parts of the document that are applicable to homosexuality and homosexual relationships.

As a preface to addressing these areas, it is probably wise to identify the ideology which seems to undergird the Guidelines. A review of the Guidelines suggests that the authors relied heavily on an ideological approach closely aligned with social constructionism. This approach is based on the work of Berger and Luckmann and suggests that all knowledge is constructed rather than discovered.[71] This ideology is based on the belief that reality is socially constructed and focuses on language as an important means by which individuals interpret experience. According to science, we make discoveries through the building and testing of hypotheses with a concerted effort to be unbiased. The constructionist, however, notes that our interests and values cannot be separated from our observations.[72]

This ideological underpinning is not an unimportant consideration considering the advocacy nature of the Guidelines.

The developmental framework of the Guidelines seems to align itself somewhat with an approach not so different from the developmental models noted above (Cognitive, Social/Emotional and Moral Development):

- Level 1: Middle Childhood, ages five through eight; early elementary school
- Level 2: Preadolescence, ages nine through twelve; later elementary school
- Level 3: Early adolescence, ages twelve through fifteen; middle school/junior high school

71. PETER L. BERGER & THOMAS LUCKMANN, THE SOCIAL CONSTRUCTION OF REALITY 24 (1966).

72. *Id.* at 20.

- Level 4: Adolescence, ages fifteen through eighteen; high school[73]

The Guidelines are structured with Key Concepts—Human Development, Relationships, Personal Skills, Sexual Behavior, Sexual Health, Society and Culture. The outcomes of the proposed instruction are categorized as Life Behaviors. Topics are individual subjects under which developmental messages are given in "age appropriate" fashion that children need to learn.[74]

Using the omission, commission and distortion categories, below are listed some of the developmental messages relevant to homosexuality and homosexual practices that are contained in the Guidelines along with a category critique.

Key Concept 1—Human Development. Topic 5—Sexual Orientation, Developmental Messages:

- Level 1: Some people are homosexual, which means that they can be attracted to and fall in love with someone of another gender.

- Level 2: Some people are bisexual, which means they can be attracted to and fall in love with people of the same or another gender; Sexual orientation is just one part of who a person is . . . . Gay men, lesbians, and bisexual people can have their own children or adopt.

- Level 3: Many scientific theories have concluded that sexual orientation cannot be changed by therapy or medicine; Many of the sexual behaviors people engage in are the same regardless of their sexual orientation; there are organizations that offer support services, hotlines, and resources for young people to talk about sexual orientation; Some internet sites offer gay, lesbian, bisexual, and heterosexual individuals the opportunity to join a community and find friendship and support.[75]

Critique. This section omits the significant research that concludes that homosexuality is not invariably fixed in all people and childhood and adolescence are times of significant fluidity. There is an omission of those scientific theories which demonstrate that psychological care can be helpful to some

73. GUIDELINES, *supra* note 70, at 17.

74. *Id.* at 15.

75. *Id.* at 29–30.

people in making changes in attractions, orientation and identity. The developmental message that "Many of the sexual behaviors people engage in are the same regardless of their sexual orientation" is a distortion of what the research actually says. For example, sexual behaviors like anal intercourse, fisting, rimming and other sexual behaviors enumerated by Dr. John Diggs are significantly higher in the homosexual population and place its participants at a higher risks for medical conditions and disease.[76] It is a distortion of science to state that "Gay men [and] lesbians . . . can have their own children." How is this biologically possible? Bailey perhaps states it best when he notes that "homosexuality remains an unexplained evolutionary paradox."[77] Gays and lesbians cannot reproduce which means that "homosexuality is evolutionarily maladaptive."[78]

Topic 6—Gender Identity, Developmental Messages:

- Level 2: Gender Identity is just one part of who a person is.
- Level 3: Transgender is also used as general term to describe many different identities that exist such as "transsexual," "drag queen," "crossdresser," "gender queer," "shape shifter," "bigendered," and "adrogyne;" . . . . Some transgender individuals may take hormones to have surgery to alter their bodies to better match their gender identity.[79]

Critique. To provide the developmental message that gender identity is just one part of who a person is suggests permanency. This is a distortion of what the research says even about the fluidity of gender identity, particularly in females. Gender Identity Disorder (GID) is a psychiatric disorder for which there is effective treatment.[80] To suggest surgery as a remedy to a psychiatric problem is not supported by the current science. It is a commission of scientific misrepresentation.

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76. DIGGS, *supra* note 62, at 2–5.

77. BAILEY, *supra* note 58, at 88.

78. *Id.* at 116.

79. GUIDELINES, *supra* note 70, at 31.

80. KENNETH ZUCKER & SUSAN BRADLEY, GENDER IDENTITY DISORDER AND PSYCHOSEXUAL PROBLEMS IN CHILDREN AND ADOLESCENTS 265, 287 (1995).

Key Concept 4—Sexual Behavior. Topic 3—Shared Sexual Behavior:

- Level 3 Some sexual behaviors shared by partners include kissing; touching; talking; caressing; massaging and oral, vaginal, or anal intercourse.[81]

Critique. This section omits the research demonstrating the dangers associated with sexual behaviors, particularly anal intercourse. In addition, recent research has reported an increasing incidence of oral cancer in young adults.[82] This is particularly disturbing because recent research indicates that 20% of ninth graders have had oral sex.[83]

Key Concept—Sexual Behavior. Topic—Sexual Fantasy:

- Level 4: People can have sexual fantasies about individuals of all genders without it necessarily affecting their understanding of their sexual orientation.[84]

Critique. To suggest that sexual fantasies are harmless has no basis in psychological science. This section omits significant research that demonstrates how destructive thoughts and fantasies can be harmful to children and adolescents. Research clearly demonstrates that adolescents engage in dangerous behaviors even when knowing the potential risks.[85] Such behaviors can indeed be motivated by fantasy. It is not lack of information or understanding that is the problem. Rather, it is the lack of judgment.

V. POTENTIAL NEGATIVE CONSEQUENCES IN THE LIVES OF CHILDREN

Of particular concern is the lack of scientific support for the developmental messages about homosexuality and homosexual relationships geared toward children via sexuality education as noted in the Guidelines.

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81. GUIDELINES, *supra* note 70, at 53.

82. Gypsyamber D'Souza et al, *Case-Control Study of Human Papillomavirus and Oropharyngeal Cancer*, 356 NEW ENG. J. MED. 1944, 1955 (2007).

83. Bonnie Halpern-Felscher et al., *Oral Versus Vaginal Sex among Adolescents: Perceptions, Attitudes, and Behavior*, 115 PEDIATRICS 845, 847 (2005).

84. GUIDELINES, *supra* note 70, at 55.

85. Laurence Steinberg, *Cognitive and Affective Development in Adolescence*, 9 TRENDS COGNITIVE SCI. 69, 72 (2005).

Of even greater concern is the potential for self-labeling that is likely to occur. Good research concludes that for adolescents each year's delay in bisexual or homosexual self-labeling reduces the odds of a suicide attempt by 20% (diminishes to 80%).[86] Such research would suggest that it would be prudent to discourage early sexual experience, discourage early self-labeling and discourage any form of sexuality education that promotes early self-labeling.

Misinformation as that noted above may have the effect of permission-giving beliefs.[87] Messages, particularly messages from authority figures to a vulnerable twelve-year-old, that anal intercourse and sexual fantasies are benign give permission and can encourage such beliefs and behaviors.

Gender flexibility can encourage the rejection of gender roles—mothers and fathers become unnecessarily deconstructed. Gender confusion can lead to experimentation.

Presenting social constructions as facts can encourage premature closure on issues surrounding sexual orientation. Suggesting permanency, when in fact fluidity is characteristic of childhood and adolescence, can lead children and adolescents to make decisions when they may neither be cognitively, affectively or morally mature to do so.

VI. CONCLUSION

Teaching respect for individuals regardless of sexual orientation or gender identity is appropriate and a desired goal for any sexuality education program. However, teaching tolerance is not the same as embracing or celebration of different expression of sexuality. Science—good science, not ideology—should serve as the foundation for education, sexuality education or otherwise. Sexuality education programs like those advocated by the Guidelines are based on a particular ideology at the exclusion of scientific findings. The Guidelines unlink child-parent biological bonds by redefining

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86. Gary Remafedi et al., *Risk Factors for Attempted Suicide in Gay and Bisexual Youth*, 87 PEDIATRICS 869, 874 (1991).

87. Mary Anne Layden, *Cyber Sex Addiction*, ADVANCES IN COGNITIVE THERAPY (Academy of Cognitive Therapy, Bala Cynwyd, Pa.), Sept. 2005, at 1, *available at* http://academyofct.org/Library/InfoManage/Displayfile.asp?InfoID=1055&SessionID={764FA4EA-AF64-4408-B6C8-E252D27E2CB5}&RC={764FA4EA-AF64-4408-B6C8E252D27E2CB5}1020116&Action=.

the family as "two or more people who care for each other in many ways."[88] It goes on to say, "Children can have a mother, a mother and a father, two mothers, two fathers, or any combination of adults who love and care for them."[89] Children and adolescents are frequently referred to "other trusted adults" or the internet, undermining parental responsibility.[90] Such messages lead to confusion as well as potential danger because children often lack judgment and discernment, thus rendering them vulnerable to others.

The information or misinformation provided in the Guidelines has the potential of sexualizing children, thus depriving them of their child-like innocence. A premature affirmation of either sexual orientation or gender identity has the potential of introducing confusion and havoc in the lives of children. Rather, children and adolescents need to be affirmed as people worthy of respect and should be encouraged to wait until adulthood to make choices about their sexuality and their sexual behavior. Premature choices, such as sexual experimentation, without the requisite judgment can lead to disease and death. We render no service to our children when we provide lifestyle options before they are able to make informed decisions about such options.

88. GUIDELINES, *supra* note 70, at 33.
89. *Id.* at 34.
90. *Id.* at 30–32, 49.