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

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1. Introduction

Schools exist ostensibly to educate children. Most would agree that education (the acquisition of knowledge through the learning process; 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 of children (Piaget), social/emotional development (Erikson, Goleman) and moral development (Kohlberg). 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 as well as moral development. With same-sex marriage entering the Public Square via sexuality education and being incorporated both directly and directly into the education curricular, it is reasonable to assume that there is a potential (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. 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 though the sequence of development is somewhat predictable that 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.

2. 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 2 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 2 to ages 6-7. During this stage of cognitive development, children are restricted in how they learn and process information. During this stage of cognitive development, children become egocentric 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 11-12. 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 and is characterized by certain developmental tasks beginning with the Trust v. Mistrust of infancy where the child’s basic needs are met, where children learn to trust the affection and comfort of caregivers through constancy. Following the Trust v. Mistrust stage, the Autonomy v. 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 v. 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. The elementary school years according to Erickson are characterized by Industry v. 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. Adolescence is center the next stage of development and is characterized by Identity v. 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 and include Intimacy v. Isolation (young adulthood) where young people are capable of forming lasting friendships and marriage. When such relationships are not formed, feelings of isolation often result. Middle age is characterized by Generativity v. Stagnation which includes a focus on satisfaction and contributions to society. The final Erickson stage is Integrity v. Despair which includes the retirement years.3

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 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 (stage) as well as the exchange of favors (stage)—with the what’s in it for me notion. Right and wrong is determined by personal consequences. The next Kohlberg level is one of 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 class room, so does human sexuality which includes homosexuality and homosexual relationships. It is important to know what science can and cannot say about homosexuality.


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: 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. 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. \[5\] In fact Friedman and Downey state: “At clinical conferences one often hears….discussants commenting that ‘homosexuality is genetic,’ and therefore, that homosexual orientation is fixed and unmodifiable. Neither assertion is true…The assertion that homosexuality is genetic is so reductionist that it must be dismissed out of hand as a general principle of psychology.”\[6\]

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.”\[7\]

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.” 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…”.

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

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.
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. Social learning theory explains how individuals learn through observations and adopt actions and attitudes from significant others. 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 more likely to self-identify as homosexual or bisexual. Friedman and Downey concluded that boys, who later identified as homosexual, became sexually active at an earlier age than did their heterosexual counterparts. Using a nonclinical population, Tomeo, Templer, Anderson, and Kotler noted that forty-six percent of gay men and twenty-two percent of lesbians were sexually abused as children, compared to seven percent of the matched heterosexual men and one percent of the
matched heterosexual women. Particularly intriguing was the finding that sixty-eight percent of the homosexual men and thirty-seven percent of the lesbian women did not self-identify as gay or lesbian until after the molestation. Steed and Templer, in their study of 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.” 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.

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 no directly cause homosexuality, but rather that set the stage for homosexuality by influencing temperament. 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 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.

Agency and Homosexual Behavior: A Neglected Area

Biological theory suggests the force of nature (genes, prenatal hormones) in 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 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.”

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. Perhaps the lesbian activist Camille Paglia said it best when she concluded, “[t]here is an element of choice in all behavior, sexual or otherwise.”

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 12 year olds reported being unsure about their sexual orientation. However, only 2-3% will self-identify as gay as adults. 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 identified. Frequently, the three distinct categories are merged in both the media and the academy, making it even difficult to discuss the term homosexuality.

Perhaps the more important questions are as follows: What can scientists say about the malleability 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. Prior to 1973, when lobbying by gay activists led to the removal of homosexuality from the psychiatric manual, psychological care was routinely provide to those who were distressed by their unwanted homosexual attractions. In reviewing the research prior to this time, Satinover reported a composite success rate of fifty percent. Masters and Johnson reported a success rate of sixty-five percent after a five year follow-up. James conducted an analysis of over a hundred studies, and reported that thirty-five percent of those with homosexual attractions “recovered,” and an additional twenty-seven percent “improved.” She concluded that significant improvement and even complete recovery from a homosexual orientation was entirely possible. More than thirty years ago, Freund, using penile plethysmography, found that some homosexual men could voluntarily alter their penile responses to respond to heterosexual stimuli without ever receiving reorientation therapy. More recently, Lisa Diamond concluded that sexual identity is far from fixed in women who are not exclusively heterosexual. 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.\textsuperscript{29} 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.\textsuperscript{30}

Other psychological studies including a national survey\textsuperscript{31} as well as a meta-analysis\textsuperscript{32} supports 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 research years which supports the malleability of homosexuality was that conducted by Dr. Robert L. Spitzer who ironically was the same psychiatrist to led the charge to remove homosexuality from the psychiatrist manual in 1973. From his study of 200 individuals, Spitzer found that sixty-six percent of the men and forty-four percent 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 that, 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; 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.\textsuperscript{33} 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.\textsuperscript{34}

Other peer-reviewed research conducted by Karten\textsuperscript{35} as well as Yarhouse and Jones\textsuperscript{36} 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.\textsuperscript{37}

C. Current Scientific Knowledge About Homosexual Relationships

Homosexual relationships differ from heterosexual relationships in major ways: Levels of promiscuity, physical health, mental health, and monogamy. 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.\textsuperscript{38} These researchers found that the vast majority of heterosexual couples were monogamous while the marriage was in tact. Ninety-four percent of married couples and seventy-five percent of cohabiting couples had only one partner in the previous 12 months.\textsuperscript{39} An extensive study on homosexuality and monogamy was conducted in 1984 by David McWhirter and Andrew Mattison.\textsuperscript{40} The Male Couple Study was designed to evaluate the quality and stability of long term male homosexual couplings. The study was actually undertaken to disprove the reputation that gay male relationships do not last. After much searching, these researchers were able to locate one hundred and fifty-six couples who had been in relationships that lasted from one to thirty-seven years. Two-thirds of the respondents in the study had entered the relationship with either the implicit or explicit expectation of sexual fidelity. The researchers found that of
the one hundred and fifty-six couples, only seven had been able to maintain sexual fidelity. Furthermore, none of the seven couples had been together for more than five years. 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.\textsuperscript{41} Dr. Colleen Hoff, author of the Gay Couple Study which followed 556 male couples for three years reported that about 50\% of those surveyed have sex outside their relationships with the full knowledge and approval of their partners.\textsuperscript{42} Prior to the AIDS epidemic, Bell and Weinberg reported that 28\% of homosexual men had more than 1000 lifetime partners.\textsuperscript{43} Michael et al reported a comparative statement: “It is extremely rare for a heterosexual who is not a prostitute to have 1100 lifetime sexual partners, as the average gay man infected with HIV had in the beginning of the epidemic.”\textsuperscript{44} The Centers for Disease Control (CDC) reported that between 1994 and 1997, the percentage of gay men reporting multiple partners increased from 23.6 percent to 33.3 percent, with the largest increase in men under 25 years of age.\textsuperscript{45} 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.”\textsuperscript{46} 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.”\textsuperscript{47} 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.\textsuperscript{48}

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.\textsuperscript{49}

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 supports the conclusion that male homosexual behaviors inherently place its 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.”\textsuperscript{50} 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 papilloma virus, Giardia lamblia, Isospora belli and Microspordia 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 refers to the insertion of a hand or forearm into the rectum, is far more damaging than anal intercourse. One researcher found that twenty-two percent of homosexuals engaged in this practice. 51 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 12 months, 30 percent had bacterial vaginosis which is associated with a higher risk for pelvic inflammatory disease and other sexually transmitted infections. 52 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 MSM in the 1980’s…are we set to backslide a mere 20 years later as HIV incidence rates move steadily upward, especially among MSM?“\(^{53}\)

Research evidence has consistently demonstrated that homosexual practices places its participants at risk for some forms of mental illness such as anxiety, depression, suicidality and multiple disorders. In the *Archives of General Psychiatry*, researchers Herrell et al 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.”\(^{54}\) 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 dependence…multiple disorders…suicidal ideation…suicide attempts.”\(^{55}\)

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.\(^{56}\)

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.\textsuperscript{57}

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 woman 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.”\textsuperscript{58}


Like education, 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.

includes the following in its Background and Introduction section: “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.”

Since these Guidelines were first developed more than 10 years ago, they are
probably the single most influential publication used by educators in 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 in 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 which is applicable to homosexuality and homosexual relationships.
As a preface to addressing these areas, it’s 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. This ideology is based on the belief that reality is socially constructed and focuses on language as important means on how 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.

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, Moral Developmental).

- Level 1: Middle Childhood, ages 5 through 8; early elementary school
- Level 2: Preadolescence, ages 9 through 12; later elementary school
- Level 3: Early adolescence, ages 12 through 15; middle school/junior high school
- Level 4: Adolescence, ages 15 through 18; high school

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. 63

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: Human Development, Topic 5: Sexual Orientation, Developmental Message Level 1: “Some people are homosexual, which means that they can be attracted to and fall in love with someone of another gender.”

Developmental Message 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.”64

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 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. 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.” Gays and lesbians cannot reproduce which means that “homosexuality is evolutionarily maladaptive.”

Topic 6 Gender Identity, Developmental Message, 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 “androgyne;” “Some transgender individuals may take hormones to have surgery to alter their bodies to better match their gender identity.”

Critique. To provide the developmental message that gender identity is just one part of who a person is suggests a 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. To suggest surgery as a remedy to a psychiatric problem is not supported by the current science. It’s a commission of scientific misrepresentation.
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.”

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

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.”

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

5. 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.
Of even greater concern is the potential for self labeling that is likely. Good research concludes that for adolescents that for each year’s delay in bisexual or homosexual self-labeling, the odds of a suicide attempt is reduce by 20% (diminishes to 80%). 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. Messages, particularly messages from authority figures to a vulnerable 12 year old that anal intercourse and sexual fantasies give permission 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.

6. 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. Sexual 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 the family as “…two or more people who care for each other in many ways.”

“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.” Children and adolescents are frequently referred to “other trusted adults” or the Internet, undermining parental responsibility. 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 love while encouraging them to wait until adulthood to make choices about their sexuality and their sexual behavior. Premature choices 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.

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2 Ibid, p. 29-42.
3 Ibid, p.73.
7 David Nimmons, Sex and the Brain, 15 Discover 64, 66 (Mar., 1994), quoting Simon LeVay.
19 William Byne & Bruce Parsons, IBID, p. 236.
37 IBID.
39 IBID.
41 IBID.
44 Robert Michael et al., IBID, p. 214.
48 IBID, p. 100.
52 IBID, p. 6.
57 Bailey, IBID, p. 884.
61 IBID
62 Guidelines, p. 17.
63 IBID, p. 15.
64 IBID, p. 29-30.
65 John Diggs, IBID.
67 IBID, p. 116.
68 Guidelines, IBID, p. 31.
70 Guidelines, IBID, p. 53.
73 Guidelines, IBID, p. 55.
77 Guidelines, P. 33
78 IBID, p. 34.
79 IBID, p. 30, 31,32,49.