AMERICAN ACADEMY OF PEDIATRICS

Committee on Adolescence

Homosexuality and Adolescence

In 1974, the American Psychiatric Association ended its classification of homosexuality as a mental disorder, labeling it rather as an alternate choice of sexual expression. This decision was based on the beliefs of the majority that there were insufficient data to label such individuals as being ill and that the deleterious social consequences of the pathologic designation were so grievous as to demand the declassification.[1]

Although theories regarding the etiology of homosexuality have been based on genetic, hormonal, psychological, and environmental models, there is little reason to believe that any one of the arguments alone explains all homosexual orientation or behavior.[2] Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available. Although little agreement exists concerning the etiology of homosexuality, and any definition of terms will be arbitrary, some operational definitions are necessary (Table).[3]

Four assertions can be made regarding homosexuality during the teenage years:

1. Some homosexual experimental behavior is experienced by many adolescents. This may include fondling of the body or genitalia or mutual masturbation. In the vast majority of cases these homosexual encounters do not predispose to later obligatory homosexuality, but appear to be a common exploratory behavior en route to conventional heterosexual development.

2. Homosexual[4] characteristics appear to be established before adolescence. Although many individuals do not participate in overt homosexual play during childhood, the self-conscious psychological state probably often exists before adolescence.

3. Some previously heterosexually oriented adolescents will become involved in homosexual activities if circumstances reinforce this behavior or if heterosexual alternatives are not available. This is termed facultative homosexuality. The majority of these individuals will ultimately revert to heterosexual practices when circumstances change. This situation is faced by large numbers of incarcerated teenagers, and to a lesser degree by teenagers in isosexual boarding school settings and military barracks.

4. The vast majority of behaviors should not be characterized as "male" or "female"[5,6] since most are common to all young people.

Teenagers, their parents, and the community organizations with which they interact may look to the pediatrician for clarification of the medical and social issues involved when the question or fact of adolescent homosexual practices arise. An appropriate history of sexual orientation and practices must be obtained before adequate medical care can be given. The pediatrician must be entirely nonjudgmental in posing sexual questions if he or she

TABLE. Definition of Terms[3]

Sexual dimorphism: The structural, physiologic, and behavioral differences between the sexes.
Gender identity: The personal sense of one's own integral maleness or femaleness.
Gender role: The public expression of gender identity; the choices and actions that signal to others a person's maleness or femaleness; one's sex role.
Homosexual identity: A personal sense of sexual orientation in which an individual believes himself or herself to be committed sexually to persons of the same sex.
Transvestite: An individual who dresses in the clothing of the opposite sex and derives pleasure from this action.
Transsexual: An individual who has been surgically changed from his or her original sex to that of the other; an individual who believes himself or herself to be of a sex different from his or her biologic and assigned sex.
Bisexual: A person who has both heterosexual and homosexual relations or an action relating to both sexes.

is to be at all effective in encouraging the teenager to share his or her concerns, experiences, and beliefs. Only with adequate information of this kind can there be proper medical assessment of the potential consequences of homosexual practice or fears. If the history includes open-ended questions about homosexual beliefs, practices, and experiences, then the pediatrician may elicit items that require either further investigation and evaluation, or possibly referral.[7] If the pediatrician, on the other hand, finds it impossible to be so objective and nonjudgmental, perhaps because of religious or moral convictions about the acts involved, he or she must be honest with the patient and, after expressing personal views in a helpful and understanding manner, offer the option of referral to another professional for treatment or counseling.

The medical consequences of homosexual activity are those that primarily result from the sexual practices of fellatio, cunnilingus, and anal intercourse. Although these practices are also utilized by heterosexuals, these behaviors should always be considered when caring for the homosexual adolescent patient. Sampling sites for sexually transmitted pathogens such as *Neisseria gonorrhoeae* and enteric organisms should always include the pharynx and rectum in teenagers engaging in these practices. The increased incidence of hepatitis B and *Giardia lamblia* infestations in these individuals must be remembered as well, as should the important new epidemic of "AIDS" (acquired immune deficiency) disease expressed by lymphadenopathy, infection with unusual pathogens, or Kaposi's sarcoma.

The social consequences of homosexual orientation in an adolescent include potential difficulties in peer group acceptance, family rejection, school and institutional harrassment, limited employment opportunities, legal difficulties, and social isolation. Although homosexual orientation does not appear to predispose to mental illness, the social consequences of this life-style in a teenager may create serious secondary emotional problems.

The American Academy of Pediatrics recognizes the physician's responsibility to provide health care for homosexual adolescents and guidance for those young people struggling with problems of sexual expression. The pediatrician can play a role in the evaluation and care of those adolescents who are concerned about their expression of sexual preference by offering reassurance to those in discomfort because of early adolescent homosexual experience; willingness to help or refer for help those in difficulty with family, peers, or institutions; and by being familiar with community resources for teenaged homosexuals and their parents if referral for social and emotional stress is required.

For adolescents who demonstrate a homosexual orientation, evaluation must include an assessment of their desires to sustain or alter their current sexual preference. Referral for psychotherapeutic support should be offered to both the adolescent who wishes to remain homosexual but is suffering psychological stress due to this decision and to the adolescent who wishes to pursue a heterosexual orientation.

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