**Sexual Attractions and Youth**

**Abstract:** Homosexual attraction describes the condition of being sexually attracted to members of the same sex. Bisexual attraction describes the condition in which individuals experience both same-sex and opposite-sex attractions. Heterosexual attraction refers to the condition of being sexually attracted exclusively to members of the opposite sex. In all cases, sexual attraction appears to be the result of the interaction of multiple factors in an individual’s life. While same-sex attractions may not in and of themselves pose a health risk to youth, homosexual sexual activity is associated with significant physical and psychological morbidities. This risk is most increased among young men who have sex with men. Individuals who identify as having same-sex attractions are more likely to engage in same-sex sexual activity. It is plausible that if sexual attractions are modifiable then same-sex sexual behavior and the risk of its associated morbidities may be reduced and/or avoided altogether. For this reason, the College conducted a review of the scientific literature regarding the causation and malleability of same-sex attractions.

**Sexual Attractions: Acquired or Innate**

The preponderance of information from quality research and analysis indicates the development of all sexual attractions is multifactorial and not purely innate.[[1]](#endnote-1) The strongest evidence that same-sex attraction in particular is not determined by inborn factors alone comes from identical twin studies. If homosexuality were a solely genetic trait like race or determined by prenatal hormones alone, then identical twins would have the same sexual orientation 100% of the time. Instead, at most, identical twins are both homosexual only 20% of the time.[[2]](#endnote-2) Dr. Francis Collins, former director of the Human Genome Project, summed it up best when he wrote sexual orientation “is not hardwired by DNA, and whatever genes are involved represent predispositions, not predetermination.”[[3]](#endnote-3)

Some researchers argue epigenetic factors may account for the discrepancy between the sexual attractions of identical twins, and also explain how the reproductively disadvantageous trait of same-sex attraction is passed to future generations. Epigenetic factors describe prenatal and/or postnatal events which influence the postnatal expression of DNA in a fashion that may be inherited by future generations. A careful analysis of the epigenetic literature, however, indicates that while epigenetics may be one influence among many, it plays only a minor role in the development of sexual attractions.[[4]](#endnote-4)

In 2002 Dr. Peter Bearman and Dr. Hannah Bruckner analyzed concordance rates among opposite-sex adolescent twins to assess how significant a genetic predisposition may be in contributing to homosexuality.[[5]](#endnote-5) The concordance rates were so low (between 5 and 7%), the authors concluded there is no significant genetic contribution to adolescent same-sex attraction. They similarly ruled out any significant hormone contribution. They concluded, "the main emphasis must point to socialization experiences."[[6]](#endnote-6) Specifically, they found "less gendered socialization during early childhood and preadolescence shapes subsequent same-sex romantic preferences."[[7]](#endnote-7) This is commensurate with findings of two older yet significant path analyses.[[8]](#endnote-8)

**Psychodynamic factors**

The psychodynamic and social learning theories of homosexuality have never been disproven. In essence, these schools of thought hold an individual's psychological reaction to objective and/or perceived traumas from parents, peers or others, as well as childhood sexual experiences and social factors, predominate in the development of homosexual attractions and behaviors.[[9]](#endnote-9) These theories dominated the psychiatric literature from the time of Freud through 1973 when, in response to political pressure and a desire to diminish unjust discrimination against those with same-sex attraction, the American Psychiatric Association voted to remove homosexuality as a diagnosis from the Diagnostic and Statistical Manual of Mental Disorder.[[10]](#endnote-10),[[11]](#endnote-11),[[12]](#endnote-12) During the three decades which followed, researchers vigorously investigated and sought to find evidence for an innate biological cause of same-sex attraction. All attempts to do so have met (and continue to meet) with failure. This has prompted some researchers to reconsider the role of psychodynamic factors in the development of sexual attractions. At least two studies since the research of Bearman and Bruckner, lend further credence to the influence of childhood trauma, and gender non-conforming behavior and family dynamics.[[13]](#endnote-13),[[14]](#endnote-14)

**Homosexual attractions during adolescence**

Adolescence is well recognized for its sexual fluidity and instability of same-sex attractions. In 2007, Savin-Williams and Ream conducted a large longitudinal study that documented changes in same-sex attraction so great between the ages of 16 and 17 that they questioned whether the concept of sexual orientation had any meaning for adolescents. Seventy-five percent of adolescents who experienced some initial same-sex attraction between the ages of 17-21 eventually developed solely opposite-sex attraction. This is in stark contrast to the stability researchers found among adolescents experiencing heterosexual attractions. Among these adolescents, fully 98% who originally identified as being solely opposite-sex remained so into adulthood.[[15]](#endnote-15) Another study demonstrating significant change away from same-sex attraction in adolescence involved 13,840 youth. Of those initially “unsure” of their sexual orientation, 66% became exclusively heterosexually attracted.[[16]](#endnote-16)

To date no studies have examined the success rates of therapeutic intervention for unwanted same-sex attractions among adolescents. However, if such high rates of change in same-sex attraction occur adventitiously, it is logical to assume that many adolescents who desire and pursue therapeutic assistance should experience success.

**Health risks of homosexual and bisexual behavior**

Youth who identify having same-sex attractions are more likely to engage in same-sex sexual activity than peers without these attractions.[[17]](#endnote-17) Due to this link between sexual attractions and behavior, there are compelling medical reasons for adolescents, especially males, distressed by unwanted same-sex attractions to seek therapeutic assistance.

For example, according to the CDC, from 2006-2009, young men who have sex with men aged 13-24 years had the greatest percentage increase in diagnosed HIV infections of all age groups.[[18]](#endnote-18) Among all adolescent males aged 13-24 years, approximately 91% of all diagnosed HIV infections were from male-to-male sexual contact.[[19]](#endnote-19) This is because receptive anal intercourse is 20 times more likely to result in acquiring HIV than is receptive vaginal intercourse.[[20]](#endnote-20)

Moreover, compared with heterosexual youth, non-heterosexual youth are at increased risk (by a median of 76% if bisexual; 63.8% if homosexual) for contracting other sexually transmitted infections, using tobacco, alcohol and other drugs, and engaging in behaviors that contribute to violence, depression and suicide.[[21]](#endnote-21)

Extensive research among adults documents these increased rates of these as well as other physical and mental illnesses even in countries that are most supportive of gay rights. This indicates that prejudice and discrimination alone cannot account for elevated rates of morbidity within this population.[[22]](#endnote-22)

Given these health risks, school programs which encourage students to "come out" as "gay" can be detrimental to questioning teens. In fact, for each year an adolescent delays labeling him or herself, the risk of suicide alone decreases by 20%.[[23]](#endnote-23)

**Efficacy of "gay affirmative" therapy**

There is not a single study among children, adolescents or adult clients investigating or demonstrating the alleged "harmlessness" or "healthfulness" of "gay affirmative" therapy, yet no therapy is free from harm. Regarding all forms of psychotherapy for any given condition a surprisingly high 14-24% of children deteriorate during psychotherapy.[[24]](#endnote-24)

Despite claims to the contrary, there is not one study demonstrating change therapy causes harm greater than or even equal to the aforementioned "acceptable" baseline deterioration.[[25]](#endnote-25) The research most often cited as “proving harm" from change therapy is a 2002 study of a sample of dissatisfied adult clients by Shidlo and Schroeder. The authors themselves never claimed to have "proven harm." Instead, they stated quite the opposite: “[This study does] not provide information on the incidence and prevalence of failure, success, harm, help or ethical violations in conversion therapy [i.e., change therapy].”[[26]](#endnote-26) More recently, four similar studies have also been cited.

The reason these four studies fail to prove harm is because, like the majority of client satisfaction surveys for any therapy, the research was not scientifically controlled with a non-biased sample, randomized, large-scale, prospective or longitudinal.[[27]](#endnote-27) While there are no studies of this design evaluating success rates for change therapy either, there is a vast collection of scientific literature similar in design and quality to Shidlo and Schroeder's work which documents positive outcomes for adult clients seeking therapeutic assistance with change of sexual attraction.[[28]](#endnote-28)

**Conclusion**

In summary, same-sex attractions are a result of many factors and are not simply innate. Even in the absence of therapeutic assistance, homosexual attractions are highly fluid during adolescence. Homosexual behavior is more common among youth who identify having same-sex attractions, and this behavior is associated with significant medical and psychological morbidity particularly for young men who have sex with men. Therefore, the College supports distressed adolescents' right to choose therapy for unwanted homosexual attractions with full informed consent and under the care of experts in the field.

1. Whitehead, N.E. My Genes Made Me Do It, "Are Heterosexuals Born That Way?" (chapter 1 of online book accessed August 5, 2014) pp.60-94. [↑](#endnote-ref-1)
2. Collins, F. The Language of God: A Scientist Presents Evidence for Belief. New York. Free Press. 2007 (p.260). [↑](#endnote-ref-2)
3. Ibid. P.263. [↑](#endnote-ref-3)
4. Whitehead, N.E. "Is epigenetics a critical factor in homosexuality?" http://www.mygenes.co.nz/epigenetics.htm [posted December 2012; accessed August 5, 2014]. [↑](#endnote-ref-4)
5. Bearman, P. and Bruckner, H. "Opposite Sex Twins and Adolescent Same-Sex Attraction." American Journal of Sociology, Volume 107 Number 5 (March 2002): 1179-1205 [accessed August 5, 2014 from: http://www.soc.duke.edu/~jmoody77/205a/ecp/bearman\_bruckner\_ajs.pdf] [↑](#endnote-ref-5)
6. Ibid p. 1201 [↑](#endnote-ref-6)
7. Ibid p. 1179 [↑](#endnote-ref-7)
8. Whitehead, N.E. My Genes Made Me Do It, "Path Analysis: Social Factors do Lead to Homosexuality." (chapter 11 of online book accessed August 5, 2014) pp.211-223. [↑](#endnote-ref-8)
9. Sutton, P. "What the Evidence Shows" Journal of Human Sexuality [need link from Phil] [↑](#endnote-ref-9)
10. Satinover, J. Homosexuality and the Politics of Truth [↑](#endnote-ref-10)
11. Bayer, R. [↑](#endnote-ref-11)
12. Cummings [↑](#endnote-ref-12)
13. Alanko, K., Santitila, P., Sato, B., Jem, P., Johansson, A., et.al. (2011). Testing causal models of the relationship between childhood gender atypical behavior and parent-child relationship. British Journal of Developmental Psychology, 29, 214-233. Doi: 10.1348/2044-835X.002004 [↑](#endnote-ref-13)
14. Roberts A.L., Glymour M.M., Koenen K.C. Does maltreatment in childhood affect sexual orientation in adulthood? Archives of Sexual Behavior. 2013 Feb; 42(2):161-171. Doi: 10.1007/s10508-012-0021-9. Epub 2012 September 14. [↑](#endnote-ref-14)
15. Savin-Williams, R.C. and Ream, G.L. (2007), Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood, Archives of Sexual Behavior, 36, 385-394. [↑](#endnote-ref-15)
16. Ott, M.Q., Corliss, H.L., et.al. (2011), Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics, Archives of Sexual Behavior, June; 40(30):519-532. Published online 2010 December 2. Doi: 10.1007/s10508-010-9691-3 [↑](#endnote-ref-16)
17. SEARCH FOR AUTHOR/STUDY [↑](#endnote-ref-17)
18. http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hiv\_factsheet\_ymsm.pdf [accessed August 5, 2014]. [↑](#endnote-ref-18)
19. Ibid. [↑](#endnote-ref-19)
20. Grossman, M. You're Teaching My Child What? Regnery Publishing, Inc. Washington, DC, (2009) p.87 [↑](#endnote-ref-20)
21. Kann, L., Olsen, E., et.al. "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12 --- Youth Risk Behavior Surveillance, Selected Sites, United States, 2001-2009." MMWR/June 6, 2011/

    Vol. 60. [↑](#endnote-ref-21)
22. Whitehead, N. E. (2010). Homosexuality and Co-Morbidities: Research and Therapeutic Implications. *Journal of Human Sexuality*, *2, 124-175.* Retrieved from http://www.scribd.com /doc/ 115506183/Journal-of-Human-Sexuality-Vol-2 [August 5, 2014] [↑](#endnote-ref-22)
23. Remafedi & Whitehead [↑](#endnote-ref-23)
24. Warren, J. S., Nelson, P. L., Mondragon, S. A., Baldwin, S. A., & Burlingame, G. M. (2010). Youth psychotherapy change trajectories and outcomes in usual care: Community mental health versus managed care settings. *Journal of Counseling and Clinical Psychology, 78(2), 144-155. doi: 10.1037/a0018544* [↑](#endnote-ref-24)
25. Rosik [↑](#endnote-ref-25)
26. Shidlo [↑](#endnote-ref-26)
27. Rosik "Shidlo and Schroeder Reincarnated" [↑](#endnote-ref-27)
28. Phelan & SUTTON

    **Links to additional information to be posted beneath the references**

    1. An explanation for how biological factors and psychosocial factors may interact and lead to a homosexual orientation in males which is accessible to laypersons written by Dr. Jeffery Satinover may be found here: http://www.narth.org/docs/pieces.html. Dr. Satinover is a psychiatrist, a past president of the C.G. Jung Foundation, and a former William James Lecturer in Psychology and Religion at Harvard University. He holds degrees from MIT, Yale, the University of Texas, and Harvard University. He is the author of Homosexuality and the Politics of Truth (Baker Books, 1996).

    2. A similarly readable account of the potential interaction of multiple influences in both males and females by Dr. Julie Harren may be found here: http://www.narth.org/docs/hom101.html.

    3. Video of Dr. Lisa Diamond presenting at Cornell University October 17, 2013 regarding the fluidity of sexual attraction and behavior: http://www.cornell.edu/video/lisa-diamond-on-sexual-fluidity-of-men-and-women

    Dr. Lisa Diamond is a researcher and professor of psychology and gender studies at the University of Utah. A self-identified lesbian and vocal supporter of gay rights, she is considered by many in her field to be one of the nation’s foremost experts on female homosexuality. More recently she extended her research to men. In this video Diamond expresses three conclusions beginning 37 minutes into the recording: 1. fluidity in identity, attraction and behavior is NOT specific to women but a general feature of human sexuality, one which is also confirmed by historical and cross-cultural literature; 2. the various sexual categories currently in use (LGBTQI, etc.) are useful *heuristics*(mental shortcuts, rules of thumb, educated guesses or stereotypes), but though “they have meaning in our culture, … we have to be careful in presuming that they represent natural phenomena” (38:55); and 3. it is “tricky” to use these categories for advocating rights based on the concept of immutability “now that we know it is not true … As a community, the queers have to stop saying: ‘Please help us, we were born this way and we can’t change’ as an argument for legal standing.” (43:15) [↑](#endnote-ref-28)