STATE OF NEW HAMPSHIRE

SB427 STUDY COMMISSION
TO STUDY ALL ASPECTS OF SAME SEX CIVIL MARRIAGE
AND THE LEGAL EQUIVALENTS THEREOF,
WHETHER REFERRED TO AS CIVIL UNIONS,
DOMESTIC PARTNERSHIPS, OR OTHERWISE

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My name is Dr. Marshall Forstein, MD. I am an Associate Professor of Psychiatry at Harvard Medical School, and Director of Psychiatry Residency Training at the Cambridge Health Alliance. I am a Distinguished Fellow of the American Psychiatric Association and a recognized national expert on human sexuality and specifically, sexual orientation. I am currently also the Co-Chair of the Task Force on Same Sex Marriage for the Massachusetts Psychiatric Society, and former medical director of mental health and addiction services of the Fenway Community Health Center, the oldest free standing community health center dedicated to the medical and mental health of the Gay, Lesbian, Bisexual and Transgender populations.

Over the last 25 years, I have reviewed hundreds of journal articles and books, and written and published in the peer reviewed professional journals about sexual orientation, "reparative therapy", gay and lesbian parenting and the psychological impact of stigma on mental health. I served on the initial Commission on Gay and Lesbian Youth in the Commonwealth of Massachusetts established by Governor William Weld to examine the experience of sexual minorities. I have been an invited lecturer at many U.S. medical schools presenting on sexual orientation issues.

Clinically I have been evaluating and treating sexual minorities for 25 years, and have supervised and been responsible for the care of hundreds of people with concerns about coming out as gay, having children or parents who are gay, or questions about parenting.

My curriculum vitae, which includes a listing of the hundreds of presentations I have made, as well as my publications in the professional literature will be shared with you at the end of my testimony. Thus, I am considered one of the psychiatrists most expert in the country in the area of sexual orientation.

I am here today to offer my expert testimony on the developing professional understanding of homosexuality and sexual orientation, and the impact of stigma and lack of support for same sex marriage on the mental health of individuals, couples, and the children of gay and lesbian parents.

Homosexuality continues to be one of the most sensitive and charged issues of our times. There is considerable evidence presented in the anthropological and sociology literature about how various cultures considered homosexuality throughout history. In western culture, the evolution of the response to sexuality has included beliefs about demonic possession, moral failing and more recently a question of psychological illness, manifested theoretically in the psychoanalytic view as arrested psychosocial development. Throughout the human experience, same sex behavior and relationships have been depicted in art and literature. Same sex relationships have alternately been exalted, envied, condemned and condoned. Suffice it to say that the response to homosexuality throughout history has been varied and not always seen as problematic, pathological, immoral or illegal. Over the past 35 years in the United States, much has been learned through both the stories and narratives of individual's lives, and the research looking at populations and individuals using accepted scientific methodologies.

Succinctly, to date, we neither have any conclusive scientific evidence about how homosexuality arises in humans, nor that there is any psychopathology that results as a consequence of a homosexual orientation. However, as you are all aware, there is no shortage of so called expert opinion about what constitutes mental health, sin, pathology and moral failing. I suggest that one of the great challenges for the Commission is to make sense of what constitutes knowledge based on evidence and science vs. personal opinion, ideology, or religious tenets. There are many conflicts in our culture between what some hold as religious beliefs that they would foster on the entire population, and what society has deemed legal rights.

A. Policies, position statements and practices of the major U.S. medical and mental health associations

I would like to chronicle the development of thinking about homosexuality as evident in the policies, position statements and practices of the major medical and mental health associations of the United States. Copies of these position statements will be found in the information I have submitted for the Commission's review.

Let me first state the essential principles of the current positions of the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American Academies of Pediatrics, Obstetrics and Gynecology, the American Psychoanalytic Association and the National Association of Social workers. Collectively, these professional organizations represent the majority of physicians, psychiatrists, psychologists, and social workers in the United States- over half a million medical and psychological health care providers. (Please see the attached policy

statement.) The following statements summarize the collective positions and policies of the afore mentioned professional groups:

1. Homosexuality is not a mental disorder or an illness that requires treatment.

The American Psychiatric Association, one of the oldest professional medical groups in the world, has historically developed the system of classification of mental disorders. Over the past 100 years, the development of reliable, replicable, population based research methodologies has significantly changed the process by which the medical field has determined what constitutes an illness, disorder, or psychopathology. Such studies for instance have provided evidence about the prevalence of psychiatric disorders found around the world in every culture such as schizophrenia, mood disorders, substance abuse disorders, personality disorders, etc.

Since 1973, Homosexuality has not been considered a mental illness in the Diagnostic and Statistical Manual [DSM] - the decision to remove homosexuality from the DSM was based on the lack of scientific evidence to support a diagnosis of a mental disorder [see attached position statements]. One of the earliest studies to challenge the original psychoanalytic view of homosexuality as arrested development was based on Evelyn Hooker's work comparing the results of psychological testing of homosexual and heterosexual men – she had a panel of so called experts who claimed that they could distinguish the two groups based on differences in psychological health and function. Unable to demonstrate such differences with a methodology respected at the time, work began to study the lives of large number of homosexuals in their social context.

In 1987, the APA further deleted the diagnosis of "ego-dystonic homosexuality" from the DSM. This category had been retained to allow mental health clinicians to treat gay men and lesbians who were not comfortable with being homosexual. Again, the literature did not support this diagnosis, and it was understood that a normal part of homosexual development, growing up gay in a hostile, often dangerous and rejecting family and society would be a wish to be heterosexual. But discomfort with homosexual orientation, (in the context of homosexuality not being a disorder per se), is in itself sometimes part of the developmental process of claiming a part of the self that is sometimes in conflict with religious teachings, family of origin values or customs. Because most gay people grow up in heterosexual families, there is a process of having to "come out" to self and then others, on the way to integrating sexual orientation into complete sense of being an individual. Discomfort with being homosexual is a result of being gay in an overtly heterosexual society, rather than a result of the internal sense of what feels "right". Not surprisingly, those who grow up in more fundamental religious families where the threat of being a sinner and going to hell for being homosexual is part of the moral teaching often have a more torturous route to self acceptance.

2. Homosexuality is a normal variant of human sexual behavior.

Studies from around the world, in the fields of anthropology, sociology, psychiatry, psychology have shown that homosexuality exists in every culture, and in almost all animal species as well. My understanding is that you have heard testimony on the existence of homosexuality in the rest of the animal kingdom.

3. There is no causative association between homosexuality and pedophilia- 95% of child sexual abuse is found in heterosexuals.

Pedophilia, and not sexual orientation, constitutes a mental disorder in the DSM. Although 95% of pedophiles are heterosexual, heterosexuality itself is not considered a mental disorder. Contrary to the claims by some, neither heterosexuality nor homosexuality is itself causative of pedophilia.

4. Children of gay and lesbian parents do as well as children from heterosexual parents.

I understand that Dr. Ellen Perrin has testified before this Commission. I am well acquainted not only with her own research but her review of the literature that I know as well. I fully concur with her summary of the literature and the conclusions she has provided for the Commission.

According to the American Psychiatric Association, between 6 and 14 million children in the United States are being raised by gay or lesbian parents. There is no evidence that the sexual orientation of the parents have any influence on the development of the sexual orientation of the children:

"Most gay parents conceived their children in prior heterosexual marriages. Recently an increasing number of gay parents have conceived children and raised them from birth either as single parents or in committed relationships. Often this is done through alternative insemination, adoption or foster parenting. Numerous studies have shown that children of gay parents are as likely to he healthy and well adjusted as children raised in heterosexual households. Children raised in gay or lesbian households do not show any greater incidence of homosexuality or gender issues than other children. Children raised in nontraditional homes with gay/lesbian parents can encounter some special challenges related to the ongoing stigma against homosexuality, but most children surmount these problems." (Please see attachment: Healthy Minds, Healthy Lives-American Psychiatric Association)

5. There is significant research in the psychiatric literature examining attempts to change sexual orientation. Not one study in a reputable journal has provided evidence that any so called "reparative therapy" does anything to change the basic sexual orientation of the study participants.

Claims by individual therapists that they have proof of such change have never been subjected to scientific scrutiny by impartial examiners. While it may be true that therapy might enable someone to curtail his or her homosexual behavior, there is no evidence that the internal sexual orientation changes to heterosexual. It is also not clear that such participants might not have begun the study with strong bisexual leanings, and chose to limit one aspect of the behavior in order to fir the expected role in society. Finally there is no long-term study confirming the lasting effect of such change.

The American Psychiatric Association policy of 2000 states:

"As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. ….APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to "First do no harm."

And the American Medical Association " opposes the use of "reparative" or "Conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based on the a priori assumption that the patient should change his/her homosexual orientation." [Policy H-160.991]

B. The Diagnostic and Statistical Manual (DSM):

To review in more detail, I'd like to explain why the American Psychiatric Association removed homosexuality from the DSM. Contrary to beliefs that this was a political act, the decision was based on the principles of the DSM-III: diagnoses for mental disorders were to be based on the presence of a constellation of subjective symptoms or objective findings that would be reliable, and replicable from observer to observer. For example, a diagnosis of depression would only be made if the person being evaluated met criteria that are consistent across populations. In the absence of a biological marker for most psychiatric disorders, criteria have been established based on large population based studies. This process employed in the development of the DSM involves hundreds of professionals, field trials, statistical scrutiny and replicated in multiple studies.

In the case of homosexuality there were no signs or symptoms of distress or dysfunction that distinguished heterosexual from homosexual men or women. Thus, homosexuality per se, according to large population based studies, did not constitute a mental disorder.

While homosexuals are not immune to the same psychiatric disorders as heterosexuals, sexual orientation itself was not found to be the cause of such disorders. What has been found is that homophobia and inequality can have adverse effects on the well being, and mental health of lesbian and gay people. The American Academy of Pediatrics' Committee on Adolescence wrote in October 1993:

"The psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred and isolation."

As an illustration of this impact on gay and lesbian people, the following table summarizes data obtained from a national survey of teenagers in the public school system. This survey is conducted throughout many states, including New England.

Risk behavior	Other	Gay/Lesbian
Was in physical fight requiring attendance by MD or RN	4%	21%
Threatened with weapon at school within past year	7%	25%
Skipped school because of threat of injury or feeling unsafe	6%	20%
Required medical attention as result of suicide attempt	4%	18%
Attempted suicide in past year	7%	33%

C. What do we know about homosexuality?

What do we mean by sexual orientation? Although homosexuality is often reduced down to the genital acts of sexual behavior, sexual orientation is more complex, and involves a psychological and spiritual component of the entire human being. People do not "choose" to be homosexual any more than those of you in the audience chose to be heterosexual. It is well documented that people can "choose" to behave sexually in any number of ways given the right situation. For example, men who are clearly heterosexual during adolescence and early adult hood who are incarcerated for many years often participate in homosexual behavior, but revert to heterosexual behavior upon leaving prison. Likewise, many homosexual men and women can choose to behave heterosexually in order to deny their same sex orientation or to "hide" in the safety of social acceptability to avoid rejection or persecution. The internal experience of both heterosexual and homosexual identity includes an affectional orientation as well as sexual: the aspect of sexual identity that has to do with the most basic, primitive and possibly important aspect of human existence: Love. Gay and lesbian people experience the feelings of love and attachment in exactly the same way as heterosexuals, although the gender of that affectional/sexual object is the same rather than different.

Studies over the last 30 years, many scientific studies, published in peer reviewed, reputable scientific journals have uncovered strong links between homosexuality and genetics and biology. No study has supported the old beliefs that homosexuality is a result of a particular family constellation (mothers and fathers don't make their sons gay, or daughters lesbian), sexual trauma, experience, genetic defect or hormonal imbalance.

Current thinking is that homosexuality, like heterosexuality, from a biopsychosocial perspective (and not a moral or religious view) is a result of a complex set of genetics, biology, and possibly intrauterine experiences leading to the same sex orientation as part

of the constitution and personality of the individual probably very early in childhood development. Although there is to date no single biological explanation for how an individual may become homo rather than hetero sexual. Sexual orientation affects one's entire being, and the range of expression of the internal desire to love is equally as variable among homosexually and heterosexually oriented people.

I'd like to address a number of issues that are often used to support anti gay attitudes, policies and legislation that would deny equal rights to gays and lesbians, and their children.

1. Homosexuality as sin.

I understand that a young gentleman testified last week about the damaging psychological effects of perceiving homosexuality as sin. Although some religions consider homosexuality to be sinful, that view is not uniformly held by the world's many religions or sects.

The concept of "marriage" evolved out of the basic psychological needs of humans to form attachments and family units to protect and raise children. Clarifying who belonged to whom, and who had responsibility to care for and protect is rooted in the most fundamental of human societies and is in fact observed in many animal species as well. Thus, the concept of a "civil marriage", or acknowledgement of such unions by others preceded a formal religious view of such unions, and I would simply point out that even in the Bible marriage was not always between one man and one woman: Jacob in fact had 4 wives through which he seeded the 12 tribes of Israel. Within our own society, polygamy was seen as "natural" and "moral" by Mormons, yet the State found it in its best interests to curtail such a religiously accepted practice.

This Commission is tasked with studying all aspects of same-sex civil marriage, and to the extent that opponents of equal rights for gay and lesbian people rely on a perception of homosexuality as sin to justify discrimination in marriage, it causes great psychological harm to the millions of gay and lesbian people in this country.

2. Homosexuality as "unnatural"

Presumably, unnatural is meant to imply "not found in nature", but is often another way of implying religious beliefs which are "God's law".

Experts usually confuse science with personal opinion and manipulate data to fit deeply held religious or political beliefs. Most of the "experts" who claim that homosexuality is a mental illness have been extruded from the professional organizations. Claims are often made that homosexuals are sociopaths, pedophiles, into bestiality, or whatever is intended to incite fear and hostility. Extreme hostility by individuals towards homosexuality, termed homophobia,

may in fact be more of a social and psychological concern than homosexuality itself. There are ongoing studies currently examining the relationship of homophobia and ambivalent psychosexual relationships.

As for the issue of natural vs. unnatural, on what basis is this determined? Left-handedness was considered unnatural for many years, and I suspect that some of you remember the days when children who were left handed were forced to write and play sports as though they were right handed. This was a failed social, educational policy as it was found to only prevent the normal development of writing skills. When left-handed children finally were permitted to use their "natural" attribute, their performance in school improved. Sexual orientation in our society has certainly been considerably more charged than handedness. Imagine the impact of being forced to hide one's sexual orientation, to behave as though one was heterosexual, and the delay developmentally in terms of social adjustment, self-esteem and emotional maturation.

3. Homosexuality is not "normal".

The concepts of normal and abnormal have specific meanings that are at variance with how the lay public uses these terms. In science, the study of species, human behavior, require a consistent language to make communication accurate and understandable from person to person. I try to make clear why these concepts are important in the consideration of granting equal civil rights to gay and lesbian people, according the right to marry and raise children in the same way as heterosexuals.

If we go back to the issue of left vs. right-handedness, we can determine that about 10% of the population is left-handed. Right-handedness is "normal", meaning that it is the usual developmental outcome mediated by genetics (like eye color, height). Left-handedness is "abnormal", meaning that it is the minority outcome developmentally. However, although "abnormal", left-handedness is now known to NOT be pathological. In other words, although it is more difficult to grow up left handed (since the world, it might be said is built for right handed people), there is no psychological, emotional, or educational deficits associated with a left-handed orientation.

D. Summary of findings and expert opinion

In my expert opinion, the greater good of society is accomplished when all citizens have the same options to marry the person of their choice, regardless of sexual orientation. Research studies overwhelmingly support the mental and physical health benefits to gay and lesbian people in general of believing that they are equal in the eyes of the law. A society that considers all people equal and conveys the same civil rights regardless of sexual orientation, race or gender, facilitates the psychological process of growing up with a healthy self-acceptance and self-esteem. The impact of stigma, particularly homophobia is well established in the mental health scientific literature.

Thus, in my opinion, I would urge this Commission to consider the following:

1. Homosexuality is a normal variant of sexuality in humans**.** Homosexuality is not a mental disorder and gay and lesbian people participate in society in much the same way as heterosexuals. All medical and mental health professional organizations support equal rights for gays and lesbians including the support for parenting. In the past year all the major mental health associations have issued strong supportive position statements on same sex marriage.

2. Families supported by the State with affirmation, and entitlements to the same rights and privileges and obligations are more stable and less likely to incur the need for intrusion by the government. Marriage clearly conveys benefits of stability, health and wellbeing.

3. The children of lesbian and gay families deserve the same legal rights and privileges as other children, and do as well as their counterparts raised in heterosexual marriages.

4. The impact of stigma and second class citizenry has significant consequences for a minority population of millions of people within the United States, and contributes to adolescent suicidality, isolation, abuse and institutionalized rejection.

I very much appreciate your time and respectfully submit this testimony in the hope that you will consider the importance of including gay and lesbian couples in the group of people entitled to have their relationships sanctioned by the government. I would be happy to answer any questions you may have.

References

Adams H, Wright L, Lohr B *"Is homophobia associated with homosexual arousal?"*, Journal of Abnormal Psychology, 105 (1996), P. 440-445

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barlow, D. H., Sakheim, D. K., & Beck, J. G. (1983). Anxiety increases sexual arousal. *Journal of Abnormal Psychology, 92,* 49-54.

Bernstein, G. S. (1994). A reply to Rowan. *Behavior Therapist, 17,* 185-186.

Berrill, K. T. (1990). Anti-gay violence and victimization in the United States: An overview. *Journal of Interpersonal Violence, 5,* 274-294.

Buss, A. H., & Perry, M. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63,* 452-459.

California Safe Schools Coalition. *Safe Place to Learn: Consequences of Harassment Based on Actual or Perceived Sexual Orientation and Gender Non-Conformity and Steps for Making Schools Safer*. San Francisco, CA: The Coalition, 2004.

Day SM. American Indians: reclaiming cultural and sexual identity. *SIECUS Report* 1995; 23(3):6-7.

de Kuyper, E. (1993). The Freudian construction of sexuality: The gay foundations of heterosexuality and straight homophobia. *Journal of Homosexuality, 24,* 137-144.

Fassinger, R. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. *Counseling Psychologist, 19,* 157-176.

Fyfe, B. (1983). “Homophobia” or homosexual bias reconsidered. *Archives of Sexual Behavior, 12,* 549-554.

Garofalo R *et al*. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics* 1998; 101:895-902.

Garofalo R *et al*. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med* 1999;153:487-93.

Gay, Lesbian, and Straight Education Network. *The 2003 National School Climate Survey: The School Related Experiences of Our Nations Lesbian, Gay, Bisexual and Transgender Youth*. New York, NY: GLSEN, 2004.

Haaga, D. (1992). Homophobia? *Journal of Social Behavior and Personality, 6,* 171-174.

Herek, G. M. (1989). Hate crimes against lesbians and gay men: Correlates and gender differences. *American Psychologist, 44,* 948-955.

Hudson, W. W., & Ricketts, W. A. (1980). A strategy for the measurement of homophobia. *Journal of Homosexuality, 5,* 356-371.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia: W. B. Saunders.

Lambda Legal and National Youth Advocacy Coalition. *Bending the Mold: An Action Kit for Transgender Youth*. New York, NY: Lambda Legal; Washington, DC: NYAC, [2005].

Lang, P. J. (1994). The varieties of emotional experiences: A mediatation on James–Lang theory. *Psychological Review, 101,* 211-221.

MacDonald, A. P. Jr. (1976). Homophobia: Its roots and meanings. *Homosexual Counseling Journal, 3,* 23-33.

Mallon GP, editor. *Social Services with Transgendered Youth*. Binghamton, NY: Harrington Park Press, 1999.

Marks, I. H., & Mathews, A. M. (1978). Brief standard self-ratings for phobic patients. *Behaviour Research and Therapy, 17,* 253-267.

Marmor, J. (1980). Overview: The multiple roots of homosexual behavior. In J. Marmor (Ed.), *Homosexual behavior—A modern reappraisal* (pp. 3–22). New York: Basic Books.

Massachusetts Dept. of Education. *Massachusetts High School Students and Sexual Orientation: Results of the 1999 Youth Risk Behavior Survey*. Boston, MA: The Dept. 1999.

Mavissikalian, N., Blanchard, E. D., Abel, G. G., & Barlow, D. H. (1975). Responses to complex erotic stimuli in homosexual and heterosexual males. *British Journal of Psychiatry, 126,* 252-257.

Morrow DF. Social work with gay and lesbian adolescents. *Social Work* 1993; 38:655-60.

Norman AD *et al*. Lesbian and bisexual women in small cities: at risk for HIV? *Public Health Reports* 1996; 111:347-52.

O'Donahue, W., & Caselles, C. E. (1993). Homophobia: Conceptual, definitional, and value issues. *Journal of Psychopathology and Behavioral Assessment, 15,* 177-195.

O'Donahue, W., & Letourneau, E. (1992). The psychometric properties of the penile tumescence assessment of child molesters. *Journal of Psychopathology and Behavioral Assessment, 14,* 123-174.

Remafedi G. Sexual orientation and youth suicide. *JAMA* 1999; 282:1291.

Rowan, A. (1994). Homophobia: A new diagnosis for DSM–V? *Behavior Therapist, 17,* 183-184.

Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. [Adolescent Medicine State-of-the-Art Reviews; v.8, no. 2] Philadelphia: Hanley & Belfus, 1997.

Savin-Williams RC. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. *J Consult Clin Psychol* 1994; 62:261-69.

Tollison, C. D., Adams, H. E., & Tollison, J. W. (1979). Cognitive and physiological indices of sexual arousal in homosexual, bisexual, and heterosexual males. *Journal of Behavioral Assessment, 1,* 305-314.

Weinberg, G. (1972). *Society and the healthy homosexual.* New York: St. Martin's Press.

Wade S *et al*. Cultural expectations and experiences: three views. *Open Hands* 1991 (Winter):9-10.

West, D. J. (1977). *Homosexuality re-examined.* Minneapolis: University of Minnesota Press.

Zuckerman, M. (1971). Physiological measures of sexual arousal in the human. *Psychological Bulletin, 75,* 297-329.