

INSTITUTIONAL HOMONEGATIVITY AGAINST THE INVISIBLE POPULATION: LGBTQ YOUTH

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Abstract

This paper examines research of the invisible population: LGBTQ (lesbian, gay, bisexual, transgender, queer) youth on the student-individual and institutional levels. LGBTQ individuals are negatively viewed in institutions such as: (1) secondary public school systems, (2) religious institutions, and (3) mental health facilities. Furthermore, LGBTQ youth encounter inner homonegativity resulting from, homophobic academic instructors, religious fundamentalism, and therapeutic treatment. Lastly, domains of support for the LGBTQ population are discussed.

Introduction

Research indicates that sexual desire for another individual begins from age 8 to 11 years old, furthermore, an individual's sexual identity ranges from 15 to 17 years old (Savin-Williams & Diamond, 2000; DePaul, Walsh, & Dam, 2009). The United States of America heavily focuses on heterosexuality as the most accepted sexual orientation exhibited through culture norms and societal expectations. Sexual orientation is described as an enduring romantic, emotional, and sexual attraction that is exhibited through same sex, opposite sex, and a combination of the two (American Psychological Association, 1998 & DePaul, Walsh, & Dam, 2009). The American Psychiatric Association (APA) in 1973 eliminated "homosexuality" as a mental disorder from the Diagnostic and Statistical Manual, 2nd Ed. in order to reshape society's knowledge of homosexuality from an illness to an expression of one's sexual identity (APA, 1973).

Sexual orientation is established through multiple factors which include hormonal, genetic, and environmental influences (Perrin, 2002). Biological based theories provide insight to understand sexual orientation. Some biological models include a "...high concordance of homosexuality among monozygotic twins and the clustering of homosexuality in family pedigrees" (Frankowski, 2004). In addition, biological model research indicates prenatal androgen exposure effects the development of sexual attraction of a fetus in the mother's womb. Some scientific research establishes a connection in males between homosexual orientation and when loci on the X chromosome has been replicated (Frankowski, 2004).

Furthermore, individuals that are homosexual or heterosexual exhibit neuroanatomic differences in sexuality dimorphic divisions of the brain (Stronski & Remafedi, 1998). Scientists continue to debate the difference between sexual orientations, in which, no scientific evidential research indicates sexual abuse, abnormal parenting, and other life events result in sexual orientation (Friedman, 1994; Stronski & Remafedi, 1998; Frankowski, 2004).

Student- Individual Level

Middle and high school classrooms of thirty students compose as many as nine LGBTQ students, which correlates to, approximately 6% of American students that classify themselves as gay or lesbian (Bochenek, Brown, & Human Rights, 2001; Murray, 2011). This statistic does not include those whom may be LGBTQ but struggle in silence with same-sex attraction or non-heteronormative orientations that cannot “come out” or expose their inner sexuality. Those that choose to expose their non-heteronormative sexuality often face hostile environments in which compose of threats of violence, unsafe academic climate, physical harassment, and other significant risks (DePaul, Walsh, & Dam, 2009). Other research indicates LGBTQ students have higher rates of suicidal ideation, dropping out of high school, self-harm, depression, homelessness, loneliness, social dissatisfaction and rejection, substance abuse, and risky sexual behavior (Cochran & Mays, 2000; D’Augelli, 2002; McDaniel, Purcell, & D’Augelli, 2001; U.S. Department of Health and Human Services, 1999).

Youth female LGBTQ individuals report an increased level of depression, drug use, and binge drinking due to the lack of connectedness and support from parental relationships compared to youth male LGBTQ individuals (Pearson & Wilkinson, 2013). Research from the 2009 New York City Youth Risk Behavior Survey, in which 11,887 respondents were surveyed, discusses the differences in drug use, depressive symptoms, and suicidal ideation between heterosexual and LGBTQ adolescents. Findings state that heterosexuals reported 30% and 26% of current alcohol use and depressive symptoms, whereas, their counterpart reported 45% and 49%. In addition, LGBTQ youth reported more than double the rates of their heterosexual counterparts of marijuana use and other illicit drugs. LGBTQ youth also reported three times higher rates of suicide attempts and ideation compared to heterosexual youth (Seil, Desai, & Smith, 2014).

Family acceptance and support plays a crucial role in an LGBTQ individual's disclosure of their sexual identity. Strained parental closeness and involvement, frail family relationships, and lack of family support correlate with a decreased well-being for an LGBTQ youth (Needham & Austin 2010; Ryan, Huebner, Diaz, & Sanchez, 2009). LGBTQ individuals whom have a closeness to parental figures and friends sustain a resilience and protection in their identity, furthermore, contributes to positive mental and physical health (Shilo & Savaya, 2012). Recent research suggests that LGBTQ youth discloses their sexual identity as early as age 16 to family members and their heterosexual friends, in which, their response to the disclosure of an LGBTQ identity is heavily feared due to

family and peer expectations and acceptance (LaSala, 2010; Savin-Williams & Ream, 2003, 2007). An LGBTQ youth whom has social contact with other LGBTQ identities provides a positive social environment, acceptance of their identity, friendship with others whom share the same identity, and role models that can be an encouragement (D'Augelli, 2006).

LGBTQ youth often experience a sexual shame in which heterosexual youth do not understand. Most children are raised in families that assume all of their family members are heterosexual, when a child is biologically attracted to the same sex this produces a comprehensive and nameless estrangement, in which consists of inner turmoil and obscured shame (Warner, 1999). Shame is a powerful force within oneself that can be debilitating and can lead to maladaptive alternate paths of self-awareness. If an individual has desires that are not accepted in the culture in which they live or has the inability to express their natural desires, this can lead to the individual to have increased defense mechanisms and potentially eliminating their ability for love, positive self-worth, and connection to others (Stein 2006).

Institutional Level

Institutions have a powerful impact on the way individuals understand sexuality although it may seem routine or unremarkable (Puri, 2006). Institutions such as media, family, religion, peer groups, and school have a profound effect on the individual's sexuality and identity. Everyday subtle messages from institutions reinforce cultural hierarchy norms,

in which, discrimination and devaluing messages indicate the individual's self-worth. When messages from institutions and the inner identity of an individual does not replicate itself, the individual may believe that they are "different" than others and attempt to adjust their inner self in order to comply with societal expectations. Religion and the scientific medicine institutions have classified homosexuals as individuals that are "sinners" and individuals with a "...abnormal sick personality" (Seidman, 2010). Furthermore, public school systems chose to ignore or allow a harassing environment for individuals with a non-heteronormative identity.

Sexual education in public secondary schools in the United States is heavily focused on heterosexual relationships, and furthermore, fail to educate students that are not heteronormative. In 2009 the Gay, Lesbian, and Straight Education Network (GLSEN) conducted a National School Climate Survey in which only 17.9% out of 7,000 LGBTQ student respondents received any curricula containing non-heteronormative sexual education. In addition, 3.8% of the respondents educational school system recognized their sexual identity and sexual orientation (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; Gowen, & Winges-Yanez, 2014). Commonly, most sexual education in public schools is composed of heterosexual topics including: contraception, sexually transmitted diseases, abstinence doctrine, reproductive anatomy, puberty, and abortion leaving LGBTQ youth to navigate their sexuality on their own. Exclusion of sexual education to LGBTQ students contributes to alienation and harm. It also encourages youth to adopt heterosexist definitions of relationships and marriage

as indicators of a healthy sexuality (Fine & McClelland, 2006; Gowen & Winges-Yanez, 2014).

State and federal policies such as Title IX of the Education Amendments of 1972, the First Amendment of the U.S. Constitution (1791) do not intentionally protect LGBTQ students from harassment, violence, and alienating academic climates (Murray 2011). According to “no homo policies” at public high schools; teachers often instruct LGBTQ students to “ignore” and “lay low” when they receive harassment from other students. Teachers also encourage LGBTQ students to “try to stay out of people’s way,” to dismiss other students obtrusive comments, and at times blame the LGBTQ student for the other student’s detrimental behavior (Elkind & Kauffman, 2014). Research indicates 13.7% of students responded that school faculty intervene “most of the time” whereas 3.4% of faculty “always” intervene when homophobic discrimination has occurred (Kosciw 2004). Public high school’s academic climate is reflected with the enforcement or un-enforcement of curriculum policies and homophobic instructors.

Religious fundamentalism has been widely known for creating homonegative prejudice towards the LGBTQ population. The world’s major religious affiliates have constructed homonegative campaigns, political agendas, and refusal of personal autonomy towards the LGBTQ population. Homonegativity is any negative disposition towards homosexuality, or any degrading language or behavior of an LGBTQ individual (Sowe, Brown, & Taylor, 2014). Furthermore, internalized homonegativity is the

negative attitude of their sexual identity within the LGBTQ individual, in which, he or she comes to adopt about themselves. Internalized homonegativity results from an inner conflict of strict religious homophobic sanctions and the biological attraction to the same sex. Research conducted in Australia compares religious and non-religious LGBTQ respondents indicates that "...religious homonegativity places LGB Christians at additional psychological risk, with particular regard to internalized homonegativity and religion-sexuality identity conflict, and that both personal and interpersonal characteristics may exacerbate this risk" (Sowe, Brown, & Taylor, 2014, p530). Religious environments that are not accepting of LGBTQ identities further exuberate poor self-esteem, depression, sexual risky behavior, psychological distress, poor sexual health, rejection sensitivity, and difficulties with interpersonal relationships (Sowe, Brown, & Taylor, 2014).

Religious prejudice can reside in institutional settings in which religion is not a primary focus. Often Americans whom are religious and non-religious facilitate homophobic language and behaviors pertaining to the LGBTQ population. Students and in some instances teachers in secondary public school systems use name calling such as "homo," "fag," "queer," and "dyke" when bullying LGBTQ and heterosexual students. A common phrase that is heard and repeated in the hallways is "that's so gay." Many students and teachers disregard phrases that are similar in context because they do not see any harm or prejudice towards the LGBTQ student. Degrading religious phrases such as "sinner" and

“you’re going to hell” are biblical representations of homosexuality that students and teachers alike engage in mistreatment of the LGBTQ youth. Often students that partake in homophobic name calling and religious phrases are not punished, thus, continues the cycle of discrimination, harassing, and unsafe academic culture.

Mental health facilities have focused on sexual re-orientation therapy known as Sexual Orientation Change Efforts (SOCE) for minors and affectional reorientation therapy. Mental health providers once classified homosexuality as a mental illness, and therefore, sought to alter an individual’s sexual desire towards another individual. SOCE therapy for minors consisted of talk psychotherapy and behavioral therapy. Examples of behavioral therapy consists of encounters with prostitutes, excessive bicycle riding, masturbating to heterosexual pictures to reassign sexual urges, and physical abuse (Cella, 2014). These harmful therapies further debilitated their homosexual patients to a higher degree of internal shame and anxiety into adulthood (Cella, 2014). In 2012 and 2013 states such as California, New Jersey, Ohio, New York, Pennsylvania, Florida, Minnesota, District of Columbia, Maryland, Washington, and Wisconsin have current state laws and bills to prohibit SOCE therapy to minors (Cella, 2014).

Affectional reorientation therapy is form of SOCE in which focuses on religious fundamentalism, to convert or repair an adolescents homosexual identity into heterosexual identity. Affectional reorientation therapy consisted of electric shock therapy on the genitalia, legs, and hands and consumption of chemicals or nausea-inducing drugs in

conjunction with nude photographs of same-sex individuals (Walker, 2013). Additional types of therapy include constant electric shock to produce convulsions or grand ma seizures, testicle implantation and castration in males, brain lobotomies, and given hormones such as testosterone and androgen (Murphy, 1997). Religious motivation from parents or internal homonegativity of LGBTQ individuals attempted to ride themselves of same sexual attraction underwent affectional reorientation therapy in which most commonly harm was caused and treatment was not proven effective (Walker, 2013).

Domains of Support

Public secondary school systems can positively enhance LGBTQ youth in subtle ways that can change academic culture. When students are learning about anatomy and biological functions, sexuality can be addressed and the various biological mechanisms that determine sexual attraction and desire. Other enhancements include employing a teacher that is an open LGBTQ adult that can represent student's needs and advocate for their well-being. Additional areas include continued training for practitioners that provide a commitment to all forms of student diversity. Topics include appropriate language and terminology that encourage neutrality relating to sexual orientation and partner choice that promotes positive self-acceptance to all individuals. Mental health counselors in public school systems can furthermore create a positive environment that consists of small groups to discuss LGBTQ related issues, internalized homophobia, and provide positive unconditional support (DePaul, Walsh,

& Dam, 2009).

Sexual education received in public secondary schools systems can be modified to include all sexual orientations. Modifications include topics such as disclosure of sexual orientation or “coming out,” societal pressure to remain heterosexual, accepting oneself as an LGBTQ identity, harmful myths, risk factors, depression, and stereotypes that elude this invisible population. Public school systems can be very powerful to students, therefore, teaching and directing students to receive messages that are discriminating compared to scientifically-based regarding LGBTQ issues can impact teachers and students understanding and acceptance. In addition, LGBTQ historical figures can be researched and discussed to draw examples of positive role models for all students.

Whole school prevention can be administered through Gay-Straight Alliances in educational settings. Gay-Straight Alliance organizations focus on reducing discrimination and harassment of LGBTQ youth and advocacy to promote positive environmental factors in which at risk students encounter on a daily basis (DePaul, Walsh, & Dam, 2009). Gay-Straight Alliances can provide visibility, protection, sense of community, and acceptance to all students in which sexual orientation is promoted instead of devalued. GSAs began in the mid 1980’s and continue to flourish in the United States. Currently over 3,000 networks are in existence across the country. GSA’s are primarily lead and organized by students that desire to create awareness of LGBTQ issues and identity’s in the public school climate.

Homophobic names, phrases, and bullying can be decreased when secondary school systems implement campaigns against homophobic and transphobic bullying. When students use homophobic language, those students can receive a mandated punishment that is administered by the principle and school polices to decrease future incidents.

Religious fundamentalism can be avoided when students and adults focus on the positive aspects of religion that can be uplifting instead of the theology that homosexuality, transsexuality, and bisexuality is immoral. Recently, more religious sectors are becoming allies and welcome individuals that identify as non-heteronormative. Religion and sexuality can harmoniously co-exist with an individual, community, institution, and society. Religions that partake in homophobic doctrine can be redirected to those that welcome LGBTQ youth. When an LGBTQ has a strong tie and community involvement, the harassing academic climate they encounter can be detracted and the youth can better navigate their way through such circumstances that could otherwise be highly detrimental.

Therapeutic treatment is available for LGBTQ youth that include acceptance of one's identity, strengthening family relationships, suicide prevention, and increased self-esteem called Attachment-Based Family Therapy (ABFT). ABFT, a family therapy, focuses on the parent and child relationship in which a secure bond or attachment is formed in order for the child to feel accepted, protected, and cared for in times of need. ABFT and LGBTQ youth have reported positive effects in adolescents including higher self-esteem, decreased isolation, increase of hope-

fulness, lower anxiety, more direct communication, improved emotional control, and improved family dynamics (Diamond, Diamond, Levy, Closs, Ladipo, & Siqueland, 2013). ABFT can be utilized as another domain of support for LGBTQ youth to promote self-autonomy, repair family relations, and foster hope for this vulnerable and often invisible population.

Conclusion

Currently there are stereotypes, prejudice, and misconceptions about homosexuality, transsexuality, and bisexuality among institutions that are passed down from one generation to the next. Common misconceptions include that homosexuality is deviant or abnormal. Due to this theology there is resistance to discuss LGBTQ issues in fear of “encouraging such behaviors,” “turning the youth gay.” Additional homophobia includes encouraging or ignoring homophobic responses that reinforce discrimination (Travers & Schneider, 1996). This fear needs to be challenged and replaced with scientific research and acceptance to allow for a society that values a human life instead of placing hierarchical trajectories that stratify them. Much progress has been implemented in regards to legalizing same sex marriage, although, progress is needed regarding employment occupations and the continual breakdown of stereotypes. Through education, societal advancement, and tolerance of all individuals a new atmosphere of change can be enacted. Amber Hollibaugh in 2000, summed up a final thought to consider “To fight for a world which values human sexual possibility without extracting a terrible human price. To battle human greed and human fear in any of its forms. To create a move-

ment willing to live the politics of sexual danger in order to create a culture of human hope. This is my dream today” (Hollibaugh, 2000, p.269).

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