



Compendium of Health
Profession Association
LGBT Policy & Position
Statements

www.glma.org

Table of Contents

[Introduction](#)

[American Academy of Family Physicians](#)

- Health Benefits
- Children's Health
- Family, Definition of
- Adolescent Health Care
- Reparative Therapy
- Tobacco Use Among Special Populations
- Tobacco Use Prevention
- Resolution: Healthy Benefits of Same Gender Marriage - Not Just a Social Issue

[American Academy of Nursing](#)

- Position Statement on Health Care for Sexual Minority and Gender Diverse Populations
- Support for Marriage Equality

[American Academy of Pediatrics](#)

- Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience
- Tobacco Use: A Pediatric Disease
- Prevention of Sexual Harassment in the Workplace and Educational Settings
- Consensus Statement on Management of Intersex Disorders
- Reducing the Risk of HIV Infection Associated With Illicit Drug Use
- Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy
- Families and Adoption: The Pediatrician's Role in Supporting Communication
- Coparent or Second-Parent Adoption by Same-Sex Parents
- Sexuality Education for Children and Adolescents
- Education of Children With Human Immunodeficiency Virus Infection
- Firearm-Related Injuries Affecting the Pediatric Population
- Suicide and Suicide Attempts in Adolescents
- Pediatric Guidelines for Infection Control of Human Immunodeficiency Virus (Acquired Immunodeficiency Virus) in Hospitals, Medical Offices, Schools, and Other Settings

[American College of Emergency Physicians](#)

- Non-Discrimination

[American College of Nurse-Midwives](#)

- Transgender/Transsexual/Gender Variant Health Care

[American College of Obstetrics and Gynecology](#)

- Health Care for Transgender Individuals

[American College of Physicians](#)

- Medicine and the Law
- Equal Opportunity
- Core Principles on Health Disparities and Disease Prevention
- Eliminating Racial and Ethnic Disparities in Health Care
- The Physician's Relationship to Other Clinicians
- Core Principles on Patient Rights, System Accountability, and Professionalism
- Core Principles on Physician Workforce and Graduate Medical Education

[American Medical Association](#)

- Continued Support of Human Rights and Freedom
- Nondiscrimination Policy
- Civil Rights Restoration
- Discrimination
- Council on Ethical and Judicial Affairs
- Civil Rights and Professional Responsibility
- Patient-Physician Relationship: Respect for Law and Human Rights
- Strategies for Enhancing Diversity in the Physician Workforce
- Discrimination
- Nondiscrimination Toward Medical School and Residency Applicants
- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
- Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
- Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation
- Teacher-Learner Relationship in Medical Education
- Medical Staff Development Plans
- Potential Patients
- Health Care Needs of the Homosexual Population
- Health Care Disparities in Same-Sex Partner Households
- Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population
- Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population
- Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients
- Repeal of "Don't Ask, Don't Tell"
- Legal Restrictions on Sexual Behavior Between Consenting Adults
- Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families
- Health Care Disparities in Same-Sex Partner Households

- Revision of the Lifetime Deferral for Blood Donation of the Men Who Have Sex with Men (MSM) Population
- Partner Co-Adoption
- School Violence
- Sexual Orientation as an Exclusionary Criterion for Youth Organization
- Sexual Orientation and/or Gender Identity as Health Insurance Criteria
- Removing Financial Barriers to Care for Transgender Patient
- Equity in Health Care for Domestic Partnerships
- Hospital Visitation Privileges for GLBT Patients
- Improving Sexual History Curriculum in the Medical School
- National Health Survey

American Psychiatric Association

- Homosexuality and civil rights
- Statement on discrimination based on gender or sexual orientation
- Homosexuality and the armed services
- Homosexuality and the Immigration and Naturalization Service
- Right to Privacy
- Sexual orientation, therapies focused on attempts to change (reparative or conversion therapies)
- Adoption and Co-parenting of children by same-sex couples
- Same sex unions
- Support of legal recognition of same-sex civil marriage
- Homosexuality
- Transgender and gender variant individuals, Access to care for
- Transgender and gender variant individuals, Discrimination against

American Psychological Association

- Discrimination Against Homosexuals
- Child Custody or Placement
- Employment Rights of Gay Teachers
- Hate Crimes
- Use of Diagnoses "Homosexuality" & "Ego-dystonic Homosexuality"
- Lesbian, Gay & Bisexual Youths in the Schools
- Appropriate Therapeutic Responses to Sexual Orientation
- Sexual Orientation & Marriage
- Sexual Orientation & Military Service
- Sexual Orientation, Parents & Children
- Opposing Discriminatory Legislation & Initiatives Aimed at Lesbian, Gay & Bisexual Persons
- Transgender, Gender Identity & Gender Expression Non-discrimination
- Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

- Resolution on Marriage Equality for Same-Sex Couples

American Public Health Association

- Homosexuality and Public Health
- The Need for Public Health Research on Gender Identity and Sexual Orientation
- The Need for Acknowledging Transgendered Individuals within Research and Clinical Practice
- Proposed Resolution Condemning Actions Against Lesbian, Gay, Bisexual, and Transgender (LGBT) and HIV-Related Research and Service Delivery
- Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns
- Prevention and Control of Sexually Transmitted Infections and HIV among Performers in the Adult Film Industry

Introduction

Organization policy and position statements are an important tool in advocacy efforts to ameliorate health disparities for lesbian, gay, bisexual and transgender (LGBT) individuals and to improve the climate for LGBT health professionals. This document outlines LGBT-related policy and position statements issued by health profession associations. The statements relate to LGBT individuals, families and communities as well as LGBT health professionals.

As a multidisciplinary membership organization dedicated to improving the health and well-being of LGBT individuals and health professionals, GLMA is proud to have played a role in the development of some of these policy and position statements. It is our hope that additional health profession associations will adopt similar statements and we offer our assistance to those who would like to do so.

Acknowledgements

We would like to extend our thanks to the American Medical Association (AMA) and the AMA GLBT Advisory Committee for their work in compiling a document that significantly contributed to this resource.

Notes

Please note this compendium may not reflect all LGBT-related statements from all health profession associations; this compendium is a work-in-progress. Policy and position statements from the American Academy of Physician Assistants are forthcoming.

If you would like to add a statement and/or organization to this list, please contact us at info@glma.org. Also, please note that links to the primary source are listed when available.

GLMA's Mission

GLMA's mission is to ensure equality in healthcare for lesbian, gay, bisexual and transgender (LGBT) individuals and healthcare providers.

Contact Us:

GLMA
1326 18th St., NW
Suite 22
Washington, DC 20036
202-600-8037
www.glma.org



American Academy of Family Physicians

Health Benefits

The American Academy of Family Physicians supports the equality of health benefits to all individuals within the context of the AAFP definition of family. (1996) (2008).

<http://www.aafp.org/online/en/home/policy/policies/h/healthbenefits.html>

Children's Health

The AAFP establishes policy and is supportive of legislation which promotes a safe and 7 nurturing environment, including psychological and legal security for all children, including those 8 of adoptive or foster parents, regardless of the parents' sexual orientation. (2002) (2007)

Link not available.

Family, Definition of

The family is a group of individuals with a continuing legal, genetic and/or emotional relationship. Society relies on the family group to provide for the economic and protective needs of individuals, especially children and the elderly. (1984) (2009 COD)

<http://www.aafp.org/online/en/home/policy/policies/f/familydefinitionof.html>

Adolescent Health Care

The Academy supports the concept of basic health care services to all people of the world regardless of social, economic or political status, race, religion, or gender. (B1986) (2006)

The American Academy of Family Physicians is concerned about the sexual health of adolescents in the United States, particularly in regard to the high incidence of teenage pregnancies, the high rate of sexually transmitted infections, and the lack of comprehensive and effective sex education programs, and the increasing rates of sexual assault. The AAFP believes that an evidence-based approach to sexual health education will be effective in reducing unintended pregnancy, sexually transmitted infections, and the incidence of sexual assault. The AAFP recommends that:

- a. Effective reproductive health education, pregnancy prevention and sexually transmitted infection (STI) prevention programs such as those using a comprehensive approach to sex education includes medically accurate information on contraception and abstinence.
- b. Family physicians can educate patients that abstinence, when practiced consistently, is the most effective method of preventing unplanned pregnancy and the transmission of sexually transmitted infection(s). Responsible sexual behavior is also an effective method of preventing pregnancy and STIs.
- c. Adolescents receiving family planning services deserve patient confidentiality, and practitioners should be aware of any state laws where they provide care that may impact them and the reproductive rights of their patients.
- d. Family physicians can take an active role in the prevention of unintended teenage pregnancies and prevention of STIs, by providing appropriate guidance/counseling and

effective sex education to their adolescent patient population. Each discussion could also address STIs, likely symptoms of those infections, and the need for testing even when patients are asymptomatic.

e. Comprehensive education and counsel regarding sexual practices with adolescent patients as defined in (a) above would include discussion about vaginal, anal, oral, same-sex, and other types of sexual contact. Another critical piece of counsel is the concept of consent to sexual activity and what to do if sexual contact takes place against one's consent.

f. Family physicians are in an ideal position to encourage family members to be involved in sex education efforts. It is primarily from the family that an adolescent's values and concept of sexual and reproductive responsibility arise.

g. Family physicians can be actively involved in community efforts that initiate and implement effective education and prevention programs for unintended teenage pregnancy, STIs, and sexual assault. Health education programs from elementary to high schools should include age appropriate reproductive health education.

h. Family physicians are in an ideal position to be aware that their adolescent patients may be dealing with issues of sexual identity or orientation that impact their psychosocial and physical health. Asking open questions about sexual identity and orientation can open a dialogue on family relationships, safe sexual practices, suicide risks and other issues confronting gay, lesbian, bisexual, transgendered and questioning adolescents in a sensitive and accepting atmosphere.

<http://www.aafp.org/online/en/home/policy/policies/a/adol3.html>

Reparative Therapy

That the American Academy of Family Physicians opposes the use of “reparative” or “conversion” therapy in lesbian, gay, bisexual or transsexual individuals. (2007)

<http://www.aafp.org/online/en/home/policy/policies/r/repttherapy.html>

Tobacco Use Among Special Populations

In certain populations, the prevalence of tobacco use is higher than that in the general population.

Tobacco use poses an immediate, increased health threat to:

- Smokers who are human immunodeficiency virus-positive
- Hospitalized smokers
- Lesbian, gay, bisexual and transgender smokers
- Smokers of low socioeconomic status and/or those with limited formal education
- Smokers with comorbid conditions including cancer, cardiac disease, chronic obstructive pulmonary disease, diabetes, and asthma
- Older smokers
- Smokers with psychiatric disorders, including substance use disorders
- Racial and ethnic minority populations
- Pregnant smokers

Family physicians are often the primary health care providers for these patients who often want to quit. The AAFP encourages its members to Ask these patients about tobacco use and Act to provide evidence-based treatments to help them quit.

<http://www.aafp.org/online/en/home/policy/policies/t/tobaccoprevcess.html>

Tobacco Use Prevention

The AAFP encourages its members to talk to children and adolescents about the risks of tobacco use and to participate in community prevention programs, such as Tar Wars. Tar Wars is a tobacco-free education program for fourth and fifth grade students. It teaches children about the short-term consequences of tobacco use, the cost associated with using tobacco products, and the advertising techniques used by the tobacco industry to market their products to children. This massive state and national initiative culminates in an annual national poster contest in Washington, DC, where state winners network with family physicians, constituent chapter staff, Tar Wars coordinators, and other national tobacco control advocates. The children also visit their legislators, share their winning posters, and advocate for tobacco control and prevention issues.

Tar Wars provides an opportunity for family physicians, residents, and medical students to introduce family medicine to their community. These health professionals serve as role models in their communities as volunteer presenters in elementary schools. Tar Wars is the only tobacco prevention program for children offered by a medical specialty organization in the United States, and has reached more than 8 million children. It has been active in all 50 states, several territories, and 16 other countries.

<http://www.aafp.org/online/en/home/policy/policies/t/tobaccoprevcess.html>

Resolution No. 505 (Joint Constituency A) entitled Healthy Benefits of Same Gender Marriage - Not Just a Social Issue

Introduced by the Joint Constituency

RESOLVED, That the American Academy of Family Physicians (AAFP) support full legal equality for same-gender families to contribute to overall health and longevity, improved family stability and to benefit children of Gay, Lesbian, Bisexual, Transgender (GLBT) families.

<http://www.aafp.org/online/en/home/policy/policies/e/equalityforsamegenderfamilies.html>

[Back to Top](#)

American Academy of Nursing

Position Statement on Health Care for Sexual Minority and Gender Diverse Populations

Approved by the Board of Directors July 11, 2012

The American Academy of Nursing recognizes that diversity in sexual orientation and gender identity are variations in human sexuality that have occurred throughout history (Crompton, 2003; Haggerty, 2000). Further, lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals and populations have unique and distinct identities, cultural and psychosocial characteristics, and health care vulnerabilities and needs that should be addressed by nurses in providing health care (IOM, 2011; Eliason, Dibble & DeJoseph, 2010). However, LGBTQ people currently experience social and cultural discrimination as well as health care disparities, including inadequate access to high-quality, comprehensive, culturally sensitive, dignified and respectful health care; stigma and discrimination in health care settings; legal barriers to equal protection under the law; and lack of sufficiently educated and culturally sensitive health care professionals who can meet their unique needs (IOM, 2011; Keepnews, 2011; Mayer, Bradford, Makadon, Stall, Golhammer & Landers, 2008, Irwin, 2007; Gee, 2006; Neville & Henrickson, 2006; Fogel, 2005; Gay and Lesbian Medical Association, 2002). In accordance with its mission to influence the adoption of effective health care policies and processes, the American Academy of Nursing opposes any discrimination based on sexual orientation or gender identity in health care and in society as a whole. AAN supports advocacy and establishment of policies and initiatives that enhance the health of LGBTQ people.

<http://www.aannet.org/assets/lgbtq%20overachstatement%20final%207%2011%2012.pdf>

Support for Marriage Equality

Approved by Board of Directors July 11, 2012

The American Academy of Nursing declares its support for marriage equality. The Academy:

- Opposes all laws, including constitutional amendments, that prohibit same-sex marriage or otherwise restrict marriage equality;
- Supports efforts to overturn or repeal the federal Defense of Marriage Act;
- Will collaborate with other nursing organizations to take similar stands;
- Brings nursing's important perspective to the ongoing discussion and debate on this important human rights and civil rights issue.

http://www.aannet.org/assets/docs/marriage%20equality_7-26%2012f.pdf

[Back to Top](#)

American Academy of Pediatrics

Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience

Pediatrics 2009 124: 1689-1693.

Committee on Bioethics

Health care professionals may have moral objections to particular medical interventions. They may refuse to provide or cooperate in the provision of these interventions. Such objections are referred to as conscientious objections. Although it may be difficult to characterize or validate claims of conscience, respecting the individual physician's moral integrity is important. Conflicts arise when claims of conscience impede a patient's access to medical information or care. A physician's conscientious objection to certain interventions or treatments may be constrained in some situations. Physicians have a duty to disclose to prospective patients treatments they refuse to perform. As part of informed consent, physicians also have a duty to inform their patients of all relevant and legally available treatment options, including options to which they object. They have a moral obligation to refer patients to other health care professionals who are willing to provide those services when failing to do so would cause harm to the patient, and they have a duty to treat patients in emergencies when referral would significantly increase the probability of mortality or serious morbidity. Conversely, the health care system should make reasonable accommodations for physicians with conscientious objections.

<http://pediatrics.aappublications.org/content/124/6/1689.abstract>

Tobacco Use: A Pediatric Disease

Pediatrics 2009 124: 1474-1487.

Committee on Environmental Health, Committee on Substance Abuse, Committee on Adolescence, and Committee on Native American Child Health

Tobacco use and secondhand tobacco-smoke (SHS) exposure are major national and international health concerns. Pediatricians and other clinicians who care for children are uniquely positioned to assist patients and families with tobacco-use prevention and treatment. Understanding the nature and extent of tobacco use and SHS exposure is an essential first step toward the goal of eliminating tobacco use and its consequences in the pediatric population. The next steps include counseling patients and family members to avoid SHS exposures or cease tobacco use; advocacy for policies that protect children from SHS exposure; and elimination of tobacco use in the media, public places, and homes. Three overarching principles of this policy can be identified: (1) there is no safe way to use tobacco; (2) there is no safe level or duration of exposure to SHS; and (3) the financial and political power of individuals, organizations, and government should be used to support tobacco control. Pediatricians are advised not to smoke or use tobacco; to make their homes, cars, and workplaces tobacco free; to consider tobacco control when making personal and professional decisions; to support and advocate for comprehensive tobacco control; and to advise parents and patients not to start using tobacco or to quit if they are

already using tobacco. Prohibiting both tobacco advertising and the use of tobacco products in the media is recommended. Recommendations for eliminating SHS exposure and reducing tobacco use include attaining universal (1) smoke-free home, car, school, work, and play environments, both inside and outside, (2) treatment of tobacco use and dependence through employer, insurance, state, and federal supports, (3) implementation and enforcement of evidence-based tobacco-control measures in local, state, national, and international jurisdictions, and (4) financial and systems support for training in and research of effective ways to prevent and treat tobacco use and SHS exposure. Pediatricians, their staff and colleagues, and the American Academy of Pediatrics have key responsibilities in tobacco control to promote the health of children, adolescents, and young adults.

GLBT reference: “The following groups of people are more likely to use tobacco than those in the general population and should be counseled accordingly: Lesbian, gay, bisexual, and transgender children and youth^{92,93} (Table 1). Alaska Native and American Indian people. Respect for ceremonial tobacco use should be demonstrated. Current or former military personnel.”

<http://pediatrics.aappublications.org/content/124/5/1474.abstract>

Prevention of Sexual Harassment in the Workplace and Educational Settings

Pediatrics 2006 118: 1752-1756.

Committee on Pediatric Workforce

The American Academy of Pediatrics is committed to working to ensure that workplaces and educational settings in which pediatricians spend time are free of sexual harassment. The purpose of this statement is to heighten awareness and sensitivity to this important issue, recognizing that institutions, clinics, and office-based practices may have existing policies.

GLBT References:

Although not much research has been published on sexual harassment of gays and lesbians in medicine, in a survey conducted by the US-based Gay and Lesbian Medical Association, 59% of gay and lesbian medical students and physicians reported job-related discrimination.¹⁷ A survey of gay and lesbian Yale students and community members indicated that 65% were targets of verbal insults, 25% received threats of physical violence, and 42% were physically abused because of their sexual orientation. Of both male and female respondents, 12% indicated that they were sexually harassed or assaulted because of their sexual orientation.¹⁸ A survey of gay and lesbian third- and fourth-year medical students applying for residency was conducted in parallel with a survey of family practice program directors to assess attitudes and biases about sexual orientation. More than 70% of the medical students indicated that their specialty choice was influenced by their own perceptions of how other physicians in a given field would accept them. Furthermore, 8% of family medicine program directors regarded disclosure about an applicant’s homosexuality in a negative light, 25% demonstrated a neutral perspective, and 67% demonstrated an accepting attitude.¹⁹

<http://pediatrics.aappublications.org/content/118/4/1752.abstract>

Consensus Statement on Management of Intersex Disorders

Pediatrics 2006 118: e488-e500.

Peter A. Lee, Christopher P. Houk, S. Faisal Ahmed, Ieuan A. Hughes in collaboration with the participants in the International Consensus Conference on Intersex organized by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology

The birth of an intersex child prompts a long-term management strategy that involves myriad professionals working with the family. There has been progress in diagnosis, surgical techniques, understanding psychosocial issues, and recognizing and accepting the place of patient advocacy. The Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology considered it timely to review the management of intersex disorders from a broad perspective, review data on longer-term outcome, and formulate proposals for future studies. The methodology comprised establishing a number of working groups, the membership of which was drawn from 50 international experts in the field. The groups prepared previous written responses to a defined set of questions resulting from evidence-based review of the literature. At a subsequent gathering of participants, a framework for a consensus document was agreed. This article constitutes its final form.

Reducing the Risk of HIV Infection Associated With Illicit Drug Use

Pediatrics 2006 117: 566-571.

Committee on Pediatric AIDS

Substance abuse, specifically the use of illicit drugs that are administered intravenously, continues to play a role in the transmission of human immunodeficiency virus type 1 (HIV-1) among adolescents and young adults (youth). Risks of HIV-1 infection may result from direct exposure to contaminated blood through sharing of injection drug equipment and from unsafe sexual practices (while under the influence of drugs and/or in exchange for drugs). Reducing the risk of HIV-1 infection that is associated with illicit drug use requires prevention education and prompt engagement in treatment. Providing patients with education, instruction on decontamination of used injection drug equipment, improved access to sterile syringes and needles, and postexposure prophylaxis may decrease their risk of acquiring HIV-1 infection. Pediatricians should assess risk behaviors as part of every health care encounter, including queries about tobacco, alcohol, and marijuana use. The risks and benefits of postexposure prophylaxis with antiretroviral drugs should be considered for youth with a single recent (within 72 hours) high-risk exposure to HIV-1 through sharing needles/syringes with an HIV-1–infected individual or having unprotected intercourse with an individual who engages in injection drug use. Such prophylaxis must be accompanied by risk-reduction counseling, appropriate referrals for treatment, and evaluation for pregnancy and associated sexually

transmitted infections. There is an urgent need for more substance-abuse prevention and treatment programs, legislation that facilitates unencumbered access to sterile syringes, and expedient availability of reproductive health care services for sexually active youth, including voluntary HIV-1 counseling and testing.

<http://pediatrics.aappublications.org/content/117/2/566.abstract>

Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy

Pediatrics 2004 114: 1677-1685.

Committee on Pediatric Workforce

This policy statement defines culturally effective health care and describes its importance for pediatrics and the health of children. The statement also defines cultural effectiveness, cultural sensitivity, and cultural competence and describes the importance of these concepts for training in medical school, residency, and continuing medical education. The statement is based on the conviction that culturally effective health care is vital and a critical social value and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through focused curricula throughout the spectrum of lifelong learning, from premedical education and medical school through residency and continuing medical education. The American Academy of Pediatrics also believes that these educational efforts must be supported through health policy and advocacy activities that promote the delivery of culturally effective pediatric care.

GLBT:

In the years since the 1994 report, discussions of health disparities among other minority patient populations and their families have emerged and expanded the discussion of culturally effective health care. In particular, sexual orientation,¹⁰ socioeconomic status, religion, and gender have been identified as cultural factors that affect the delivery of health care. Although a comprehensive overview of how each aspect affects individuals cannot be provided here, there has been increasing recognition of the unique health and wellness concerns and potential barriers to access to quality health care for certain groups of individuals. For example, gay, lesbian, and transgendered youth are disproportionately affected by human immunodeficiency virus infection, suicide, substance use, and violence.¹¹ Varying socioeconomic circumstances present their own concerns that have been proven to have detrimental effects on the well-being of adolescents and children well into adulthood.¹² Similarly, religious issues challenge the pediatrician, as illustrated by 1 study¹³ that describes the practical implications of Islamic ethical and moral norms in pediatric clinical practice. Another attribute that has proven to affect health care is gender, as 1 study¹⁴ recounts the influence it has on patient-physician communication and consequently on health care

<http://pediatrics.aappublications.org/content/114/6/1677.abstract>

Families and Adoption: The Pediatrician's Role in Supporting Communication

Deborah Borchers and Committee on Early Childhood, Adoption, and Dependent Care
Pediatrics 2003 112: 1437-1441

Each year, more children join families through adoption. Pediatricians have an important role in assisting adoptive families in the various challenges they may face with respect to adoption. The acceptance of the differences between families formed through birth and those formed through adoption is essential in promoting positive emotional growth within the family. It is important for pediatricians to be informed about adoption and to share this knowledge with adoptive families. Parents need ongoing advice with respect to adoption issues and need to be supported in their communication with their adopted children.

GLBT:

Adoptive families are changing. Increasing numbers of single-parent families, blended families, families with gay or lesbian parents, and families with older parents are providing homes to children through adoption. More children are being placed long-term with relatives, who may or may not formalize the relationship through adoption.¹ Children may have had multiple sets of foster parents before their adoption, some of whom may maintain contact with the child after the adoption. Marked increases in the number of adoptions of children with special needs have been seen in the last 2 decades.³ There are fewer newborns and more older children being placed for adoption. Sibling groups are often placed together. Many of the children who are in need of adoptive families have complex medical, developmental, behavioral, educational, and psychological challenges. These may be the result of biological or environmental stressors experienced while the child was living with the biological family or may have been initiated or exacerbated while the child was in temporary care.⁴

<http://pediatrics.aappublications.org/content/112/6/1437.abstract>

Coparent or Second-Parent Adoption by Same-Sex Parents

Committee on Psychosocial Aspects of Child and Family Health
Pediatrics 2002 109: 339-340.

Children deserve to know that their relationships with both of their parents are stable and legally recognized. This applies to all children, whether their parents are of the same or opposite sex. The American Academy of Pediatrics recognizes that a considerable body of professional literature provides evidence that children with parents who are homosexual can have the same advantages and the same expectations for health, adjustment, and development as can children whose parents are heterosexual.¹⁻⁹ When 2 adults participate in parenting a child, they and the child deserve the serenity that comes with legal recognition.

Children born or adopted into families headed by partners who are of the same sex usually have only 1 biologic or adoptive legal parent. The other partner in a parental role is called the "coparent" or "second parent." Because these families and children need the permanence and security that are provided by having 2 fully sanctioned and

legally defined parents, the Academy supports the legal adoption of children by coparents or second parents. Denying legal parent status through adoption to coparents or second parents prevents these children from enjoying the psychological and legal security that comes from having 2 willing, capable, and loving parents. Several states have considered or enacted legislation sanctioning second-parent adoption by partners of the same sex. In addition, legislative initiatives assuring legal status equivalent to marriage for gay and lesbian partners, such as the law approving civil unions in Vermont, can also attend to providing security and permanence for the children of those partnerships.

Many states have not yet considered legislative actions to ensure the security of children whose parents are gay or lesbian. Rather, adoption has been decided by probate or family courts on a case-by-case basis. Case precedent is limited. It is important that a broad ethical mandate exist nationally that will guide the courts in providing necessary protection for children through coparent adoption. Coparent or second-parent adoption protects the child's right to maintain continuing relationships with both parents. The legal sanction provided by coparent adoption accomplishes the following:

1. Guarantees that the second parent's custody rights and responsibilities will be protected if the first parent were to die or become incapacitated. Moreover, second-parent adoption protects the child's legal right of relationships with both parents. In the absence of coparent adoption, members of the family of the legal parent, should he or she become incapacitated, might successfully challenge the surviving coparent's rights to continue to parent the child, thus causing the child to lose both parents.
2. Protects the second parent's rights to custody and visitation if the couple separates. Likewise, the child's right to maintain relationships with both parents after separation, viewed as important to a positive outcome in separation or divorce of heterosexual parents, would be protected for families with gay or lesbian parents.
3. Establishes the requirement for child support from both parents in the event of the parents' separation.
4. Ensures the child's eligibility for health benefits from both parents.
5. Provides legal grounds for either parent to provide consent for medical care and to make education, health care, and other important decisions on behalf of the child.
6. Creates the basis for financial security for children in the event of the death of either parent by ensuring eligibility to all appropriate entitlements, such as Social Security survivors benefits.

On the basis of the acknowledged desirability that children have and maintain a continuing relationship with 2 loving and supportive parents, the Academy recommends that pediatricians do the following:

- Be familiar with professional literature regarding gay and lesbian parents and their children.
- Support the right of every child and family to the financial, psychological, and legal security that results from having legally recognized parents who are committed to each other and to the welfare of their children.
- Advocate for initiatives that establish permanency through coparent or second-parent adoption for children of same-sex partners through the judicial system, legislation, and community education.

<http://pediatrics.aappublications.org/content/109/2/339.abstract>

Sexuality Education for Children and Adolescents

Pediatrics 2001 108: 498-502.

Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence

Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults. Early, exploitative, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection and acquired immunodeficiency syndrome. This statement reviews the role of the pediatrician in providing sexuality education to children, adolescents, and their families. Pediatricians should integrate sexuality education into the confidential and longitudinal relationship they develop with children, adolescents, and families to complement the education children obtain at school and at home. Pediatricians must be aware of their own attitudes, beliefs, and values so their effectiveness in discussing sexuality in the clinical setting is not limited.

LGBT reference: Children most likely to engage in earlier sexual activity include children with learning problems or low academic attainment; children with other social, behavioral, or emotional problems (including mental health disorders and substance abuse); those from low-income families; children of some ethnic minorities; victims of physical and sexual abuse; and children in families with marital discord and low levels of parental supervision.^{7,8} Risky sexual behaviors, defined as having multiple partners, having sex with strangers, or having intercourse without a latex condom, are also associated with alcohol consumption.^{7,8} Many gay, lesbian, and bisexual youth are also at high risk because of unsafe sexual practices with same or opposite sex partners and because of increased rates of depression, dropping out of school, homelessness (running away or being thrown out of the home), and substance abuse.⁹

Gay, lesbian, and bisexual youth. Maintain nonjudgmental attitudes and avoid a heterosexual bias in history taking to encourage adolescents to be open about their behaviors and feelings (see the AAP statement "Homosexuality and Adolescence").^{30,31} If adolescents are certain of homosexual or bisexual orientation, discuss advantages and potential risks of disclosure to family and peers, and support families in accepting children who identify themselves as gay, lesbian, or bisexual. Adolescents who are homosexual should be screened carefully for depression, risk of suicide, and adjustment-related mental health problems. Similar issues are important to children unsure of their sexual orientation.

Link not available.

Education of Children With Human Immunodeficiency Virus Infection

Pediatrics 2000 105: 1358-1360.

Committee on Pediatric AIDS

Treatment for human immunodeficiency virus (HIV) infection has enabled more children and youths to attend school and participate in school activities. Children and youths with HIV infection should receive the same education as those with other chronic illnesses. They may require special services, including home instruction, to provide continuity of education. Confidentiality about HIV infection status should be maintained with parental consent required for disclosure. Youths also should assent or consent as is appropriate for disclosure of their diagnosis.

Link not available.

Firearm-Related Injuries Affecting the Pediatric Population

Pediatrics 2000 105: 888-895.

Committee on Injury and Poison Prevention

This statement reaffirms the 1992 position of the American Academy of Pediatrics that the absence of guns from children's homes and communities is the most reliable and effective measure to prevent firearm-related injuries in children and adolescents. A number of specific measures are supported to reduce the destructive effects of guns in the lives of children and adolescents, including the regulation of the manufacture, sale, purchase, ownership, and use of firearms; a ban on handguns and semiautomatic assault weapons; and expanded regulations of handguns for civilian use. In addition, this statement reviews recent data, trends, prevention, and intervention strategies of the past 5 years.

GLBT:

Recognized risk factors for suicide are age; depression; use of cigarettes, alcohol, or illicit drugs; impulsiveness; gender; overall life stressors; sexual identity issues; abuse; family dysfunction; and suicidal ideation.^{33–35} Suicide attempts involving a firearm more often are fatal (91%) compared with those involving drug overdoses (23%).^{6,14} The current prioritization of suicide as a national public health issue is underscored by the recent Surgeon General's Report.³⁶

<http://pediatrics.aappublications.org/content/130/5/e1416.extract>

Suicide and Suicide Attempts in Adolescents

Pediatrics 2000 105: 871-874. (REVISED)

Committee on Adolescence

Suicide is the third leading cause of death for adolescents 15 to 19 years old.¹ Pediatricians can help prevent adolescent suicide by knowing the symptoms of depression and other presuicidal behavior. This statement updates the previous statement² by the American Academy of Pediatrics and assists the pediatrician in the identification and management of the adolescent at risk for suicide. The extent to which pediatricians provide appropriate care for suicidal adolescents depends on their knowledge, skill, comfort with the topic, and ready access to appropriate

community resources. All teenagers with suicidal symptoms should know that their pleas for assistance are heard and that pediatricians are willing to serve as advocates to help resolve the crisis.

GLBT:

A statewide survey of students in grades 7 through 12 found that 28.1% of bisexual and homosexual males and 20.5% of bisexual and homosexual females had reported attempting suicide. Gay and bisexual adolescents have been reported to exhibit high rates of depression and have been reported to have rates of suicidal ideation and attempts 3 times higher than other adolescents.

Link not available.

Pediatric Guidelines for Infection Control of Human Immunodeficiency Virus (Acquired Immunodeficiency Virus) in Hospitals, Medical Offices, Schools, and Other Settings

Pediatrics 1988 82: 801-807.

Task Force on Pediatric AIDS

Acquired immunodeficiency syndrome (AIDS), the most severe manifestation of infection with the human immunodeficiency virus (HIV), has been diagnosed in more than 900 children younger than 13 years of age throughout the United States as of May 1988, 77% of whom were infected in utero or perinatally secondary to maternal infection. Risk factors for maternal infection include intravenous drug abuse or sexual contact with partners who are intravenous drug abusers or bisexual. The remainder of children, including a high proportion of hemophiliacs, have been infected by blood or clotting factor infusion between 1979 and 1985. In addition, adolescents have acquired infection through sexual activity and intravenous drug use, as well as transfusion of contaminated blood or blood factors.

The criteria for diagnosis of AIDS in children differ in some ways from those for adults, and the most recently published diagnostic criteria (Morbidity Mortality Weekly Report, Aug 14, 1987) include the expanded spectrum of disease, such as recurrent bacterial infections and encephalopathy, as well as including children with presumptive diagnosis of AIDS-associated diseases such as lymphoid interstitial pneumonitis. There is no accurate estimate of the numbers of infected asymptomatic children or of infected children with milder symptoms that do not meet the criteria for the diagnosis of AIDS. Although most cases of pediatric HIV infection have been identified in New York City, Newark, Miami, and Los Angeles, cases are appearing in other locations. Thus, HIV infection in childhood is becoming more widespread, but in many states it is still rare.

Because the cause of AIDS is a virus transmissible from human to human, pediatric health care workers must adjust infection control guidelines to meet this new threat.

Link not available.

[Back to Top](#)

American College of Emergency Physicians

Non-Discrimination and Harassment

Revised and approved by the ACEP Board of Directors April 2012

Originated as CR41 titled, "Non-Discrimination" and approved as a policy statement by the ACEP Board of Directors with the same title October 2005

The American College of Emergency Physicians advocates tolerance and respect for the dignity of each individual and opposes all forms of discrimination and harassment against patients and emergency medicine staff on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military status, gender, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law.

<http://www.acep.org/Clinical---Practice-Management/Non-Discrimination/>

[Back to Top](#)

American College of Nurse-Midwives

Transgender/Transsexual/Gender Variant Health Care

The American College of Nurse-Midwives (ACNM) supports efforts to provide transgender, transsexual, and gender variant individuals with access to safe, comprehensive, culturally competent health care and therefore endorses the 2011 World Professional Association for Transgender Health (WPATH) Standards of Care.

It is the position of ACNM that midwives:

Exhibit respect for patients with nonconforming gender identities and do not pathologize differences in gender identity or expression;

Provide care in a manner that affirms patients' gender identities and reduces the distress of gender dysphoria or refer to knowledgeable colleagues;

Become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of gender affirming treatment options;

Match treatment approaches to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria;

Have resources available to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

To facilitate these goals, ACNM is committed to:

- Work toward the incorporation of information about gender identity, expression, and development in all midwifery educational programs;
- Make available educational materials that address the identities and health care needs of gender variant individuals in order to improve midwives' cultural competence in providing care to this population;
- Support legislation and policies that prohibit discrimination based on gender expression or identity;
- Support measures to ensure full, equal, and unrestricted access to health insurance coverage for all care needed by gender variant individuals.

<http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000278/Transgender%20Gender%20Variant%20Position%20Statement%20December%202012.pdf>

[Back to Top](#)

American College of Obstetrics and Gynecology

Health Care for Transgender Individuals

Committee Opinion

Committee on Health Care for Underserved Women

Number 512, December 2011

Transgender individuals face harassment, discrimination, and rejection within our society. Lack of awareness, knowledge, and sensitivity in health care communities eventually leads to inadequate access to, underutilization of, and disparities within the health care system for this population. Although the care for these patients is often managed by a specialty team, obstetrician–gynecologists should be prepared to assist or refer transgender individuals with routine treatment and screening as well as hormonal and surgical therapies. The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder.

http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Transgender_Individuals.aspx

[Back to Top](#)

American College of Physicians

http://www.acponline.org/advocacy/acp_policy_compendium_2012.pdf

CIVIL AND HUMAN RIGHTS

Medicine and the Law

Physicians should remember that the presence of illness does not diminish the right or expectation to be treated equally. Stated another way, illness does not in and of itself change a patient's legal rights or permit a physician to ignore those legal rights.

The law is society's mechanism for establishing boundaries for conduct. Society has a right to expect that those boundaries will not be disregarded. In instances of conflict, the physician must decide whether to violate the law for the sake of what he or she considers to be the dictates of medical ethics. Such a violation may jeopardize the physician's legal position or the legal rights of the patient. It should be remembered that ethical concepts are not always fully reflected in or adopted by the law. Violation of the law for purposes of complying with one's ethical standards may have significant consequences for the physician and should be undertaken only after thorough consideration and, generally, after obtaining legal counsel. (BoR 04)

Equal Opportunity

ACP affirms a policy of not holding or supporting meetings or social gatherings at organizations and clubs that have exclusionary policies based on gender, race, color, religion, national origin or sexual orientation. ACP shall not pay for, or reimburse, the dues of any member, officer, or employee for membership in clubs which have exclusionary policies based on gender, race, color, religion, national origin or sexual orientation. (HoD 90; reaffirmed BoR 04)

DISPARITIES

Core Principles on Health Disparities and Disease Prevention

1. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities. (ACP 90; reaffirmed BoR 11)
2. Health reform should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
 - a. Health reform proposals should be designed to address barriers to care in inner city, rural and other underserved communities.
 - b. Health reform proposals should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients. (BoR 00, reaffirmed BoR 11)

Eliminating Racial and Ethnic Disparities in Health Care

1. Providing all legal residents with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.

2. All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high quality health care.
3. As our society increasingly becomes racially and ethnically diverse, physicians and other health care professionals need to acknowledge the cultural, informational, and linguistic needs of their patients. Health literacy among racial and ethnic minorities must be strengthened in a culturally and linguistically sensitive manner.
4. Physicians and other health care professionals must be sensitive to cultural diversity among patients and recognize that preconceived perceptions of minority patients may play a role in their treatment and contribute to disparities in health care among racial and ethnic minorities. Initiatives such as cultural competency training should be incorporated into medical school curricula to improve cultural awareness and sensitivity.
5. The health care delivery system must be reformed to ensure that patient-centered medical care is easily accessible to racial and ethnic minorities and physicians are enabled with the resources to deliver quality care.
6. A diverse health care workforce that is more representative of those they serve is crucial to promote understanding among physicians and other health care professionals and patients, facilitate quality care, and promote equity in the health care system.
 - a. Education of minority students at all educational levels, especially in the fields of math and science, needs to be strengthened and enhanced to create a larger pool of qualified minority applicants for medical school.
 - b. Medical and other health professional schools should revitalize efforts to improve matriculation and graduation rates of minority students. ACP supports policies that allow institutions of higher education to consider a person's race and ethnicity as one factor in determining admissions in order to counter the impact of current discriminatory practices and the legacy of past discrimination practices. Programs that provide outreach to encourage minority enrollment in medical and health professional schools should be maintained, reinstated, and expanded.
 - c. Medical schools need to increase efforts to recruit and retain minority faculty.
 - d. Efforts should be made to hire and promote minorities in leadership positions in all arenas of the health care workforce.
 - e. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals in minority communities.
7. Social determinants of health are a significant source of health disparities among racial and ethnic minorities. Inequities in education, housing, job security, and environmental health must be erased if health disparities are to be effectively addressed.
8. Efforts must be made to reduce the effect of environmental stressors that disproportionately threaten to harm the health and well-being of racial and ethnic communities.
9. More research and data collection related to racial and ethnic health disparities is needed to empower stakeholders to better understand and address the problem of disparities. (BoR 10)

ETHICS (excerpted)

The Physician's Relationship to Other Clinicians

Physicians share a commitment to care for ill persons with an increasingly broad team of clinicians. The team's ability to care effectively for the patient depends on the ability of individual persons to treat each other with integrity, honesty, and respect in daily professional interactions regardless of race, religion, ethnicity, nationality, sex, sexual orientation, age, or disability. Particular attention is warranted with regard to certain types of relationships and power imbalances that could be abusive or exploitative or lead to harassment, such as those between attending physician and resident, instructor and medical student, or physician and nurse. (BoR 04)

HEALTH INSURANCE (excerpted)

Core Principles on Patient Rights, System Accountability, and Professionalism

1. Health reform proposals should promote accountability at all levels of the system for quality, cost, access, and patient safety.
 - a. These could include incentives for physicians and other health care professionals to participate in the design of systems of accountability. Non-punitive and educational approaches should be favored over ones that rely on sanctions.
 - b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
 - c. Innovation and improvement should be fostered (ACP 90; reaffirmed BoR 00), including innovation in use of health information technologies to improve access, quality, and health care delivery with safeguards to protect the confidentiality of medical information that is transmitted electronically.
 - d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and predetermined benefits.
2. The medical profession must embrace its responsibility to participate in the development of reforms to improve the U.S. health care system.
3. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
4. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences. (BoR 11)

MEDICAL EDUCATION (excerpted)

Core Principles on Physician Workforce and Graduate Medical Education

1. Undergraduate medical school class size and the total number of students graduating from U.S. allopathic and osteopathic medical schools should reflect national needs and requirements for physicians. Action should be instituted promptly due to the long medical education pipeline that takes up to twelve years or more from the start of undergraduate medical education until the completion of residency training.
2. All members of society benefit from having well-trained physicians and appropriately funded academic medical centers. Consequently, all health care payers should share in the costs of graduate medical education.
3. The number of graduate allopathic and osteopathic residency training positions should be reduced and related to the total number of U.S. medical school graduates plus an additional amount to allow some opportunities for international medical school graduates, retraining of physicians engaged in career changes, and flexibility in the system to accommodate transfers, interruptions of training, and turnover.
4. Physicians should be educated and trained in sufficient proportion to meet the nation's need for a balanced mix of physicians among generalists and specialists.
5. The expanding roles and increasing numbers of non-physician health care professionals must be taken into consideration in workforce planning, and the supply of these health care professionals should also be adjusted to reflect national needs and requirements.
6. Workforce policy should seek to improve the geographic distribution of physicians. Existing incentives should be expanded and/or new incentives should be developed to encourage all health care professionals to help meet the health care service needs of underserved populations, particularly in urban and rural areas.
7. There should be no discrimination based on age, sex, national origin, religion, sexual orientation, or political affiliation for career opportunities in medicine.
8. Funding for Graduate Medical Education should be sufficient, predictable and stable to support the academic, patient care, and research missions of teaching hospitals and ambulatory training sites. Financing must be sufficient to support teaching hospitals that provide a disproportionate share of care to indigent and medically under-insured patients. (BoR 00; reaffirmed as amended BoR 06)

[Back to Top](#)

American Medical Association

<http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-advvisory-committee/ama-policy-regarding-sexual-orientation.page>

General Policies:

Continued Support of Human Rights and Freedom

H-65.992

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05; Modified: BOT Rep. 11, A-07)

Nondiscrimination Policy

H-65.983

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03; Modified: BOT Rep. 11, A-07)

Civil Rights Restoration

H-65.990

The AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03)

Physician-centered policies:

Discrimination

B-1.50

Membership in any category of the AMA or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

Council on Ethical and Judicial Affairs

B-6.524

To receive appeals filed by applicants who allege that they, because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age, or for any other reason unrelated to character or competence have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or in the event of repeated violations, recommend to the House of Delegates that the constituent and/or component

association involved be declared to be no longer a constituent and/or component member of the AMA.

Civil Rights and Professional Responsibility

E-9.03

Opportunities in medical society activities or membership, medical education and training, employment, and all other aspects of professional endeavors should not be denied to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, sex, sexual orientation, gender identity, age, or handicap. (IV) Issued prior to April 1977; Updated June 1994; Updated 2007

Patient-Physician Relationship: Respect for Law and Human Rights

E-9.12

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI) Issued July 1986; Updated June 1994.

Strategies for Enhancing Diversity in the Physician Workforce

H-200.951

Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. (CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08)

Discrimination

G-630.130

It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation. (Res. 101, I-90; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: BOT Rep. 11, A-07)

Nondiscrimination Toward Medical School and Residency Applicants

H-295.969

Our AMA urges (1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation"; and (2) the Accreditation Council for Graduate Medical Education to amend the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents" to read: "There must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity or sexual

orientation." (Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07).

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
H-310.919

Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion. 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process. 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants. (Res. 307, A-09)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11)

Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation
D-295.995

Our AMA will urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a nondiscriminatory statement related to all aspects of medical education, and to specify that the statement must address sexual orientation and gender identity. (Res. 305, A-99; Modified: BOT Rep. 11, A-07)

Teacher-Learner Relationship in Medical Education
H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues

for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct. A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher. In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty. Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication. On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians. While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role

(including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively. Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07)

Medical Staff Development Plans

H-225.961

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. 2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. (BOT Rep. 14, A-98)

Potential Patients

E-10.05

(1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship. (2) The following instances identify the limits on physicians' prerogative: (a) Physicians should

respond to the best of their ability in cases of medical emergency (Opinion 8.11, "Neglect of Patient"). (b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, gender identity or any other criteria that would constitute invidious discrimination (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing"). (c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015, "The Patient-Physician Relationship"). Exceptions to this requirement may exist when patient care is ultimately compromised by the contractual arrangement. (3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when: (a) The treatment request is beyond the physician's current competence. (b) The treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid Medical Treatment"). (c) A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs. (4) Physicians, as professionals and members of society, should work to assure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship").* Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the care provided to existing patients. When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX) Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. Updated December 2003. * Considerations in determining an adequate level of health care are outlined in Opinion 2.095, "The Provision of Adequate Health Care."

Patient-centered policies:

Health Care Needs of the Homosexual Population

H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their homosexual patients; (iii) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (iv) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (v) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (c) opposes, the use

of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation. 2. Our AMA will (a) educate physicians regarding: (i) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk. 3. Our AMA will use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing physician competency on gay, lesbian, bisexual, and transgender health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high quality and culturally competent care to gay men and lesbians. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08)

Health Care Disparities in Same-Sex Partner Households

H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households. (CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11)

Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement. (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

D-65.996

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients

H-460.907

Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. (Res. 512, A-11)

Repeal of "Don't Ask, Don't Tell"

H-65.972

Our American Medical Association will advocate for repeal of "Don't Ask, Don't Tell," the common term for the policy regarding gay and lesbian individuals serving openly in the U.S. military as mandated by federal law Pub.L. 103-160 and codified at 10 U.S.C. § 654, the title of which is "Policy concerning homosexuality in the armed forces." (Res. 917, I-09)

H-270.997 Legal Restrictions on Sexual Behavior Between Consenting Adults.

Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent. (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families

D-65.995

Our AMA will work to reduce the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05)

Health Care Disparities in Same-Sex Partner Households

D-160.979

Our AMA will evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage. (Res. 522, A-08)

Revision of the Lifetime Deferral for Blood Donation of the Men Who Have Sex with Men (MSM) Population

H-50.974

Our AMA recognizes that based on existing scientific evidence and risk assessment models, a shift to a 5-year deferral policy for blood donation from men who have sex with men (MSM) is supportable. (CSAPH Rep. 5, A-08)

Partner Co-Adoption

H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (Res. 204, A-04)

School Violence

D-515.997

Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation or gender identity, and similar behaviors and attitudes. (CSA Rep. 11, I-99; Modified: BOT Rep. 11, A-07)

Sexual Orientation as an Exclusionary Criterion for Youth Organization

H-65.979

Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation or gender identity. (Res. 414, A-01; Modified: BOT Rep. 11, A-07)

Sexual Orientation and/or Gender Identity as Health Insurance Criteria

H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07)

Removing Financial Barriers to Care for Transgender Patients

H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician. (Res. 122; A-08)

Equity in Health Care for Domestic Partnerships

H-185.958

Our AMA: (1) encourages the development of domestic partner health care benefits in the public and private sector; and (2) supports equity of pre-tax health care benefits for domestic partnerships. (Res. 101, I-01)

Hospital Visitation Privileges for GLBT Patients

H-215.965

Our AMA encourages all hospitals to add to their rules and regulations, and to their Patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. (Res. 733, A-06)

Improving Sexual History Curriculum in the Medical School

H-295.879

Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports the creation of a national public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being. (Res. 314, A-05)

National Health Survey

H-440.885

Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior. (CSA Rep. 4, A-03; Modified: BOT Rep. 11, A-07)

[Back to Top](#)

American Psychiatric Association

Homosexuality and civil rights

Approved by the Board of Trustees, December 1973

Approved by the Assembly, 1973

WHEREAS HOMOSEXUALITY per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, therefore, be it resolved that the American Psychiatric Association deplores all public and private discrimination against homosexuals in such areas as employment, housing, public accommodation, and licensing, and declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon homosexuals greater than that imposed on any other persons. Further, the American Psychiatric Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer homosexual citizens the same protections now guaranteed to others on the basis of race, creed, color, etc. Further, the American Psychiatric Association supports and urges the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private.

(The American Psychiatric Association is, of course, aware that many other persons in addition to homosexuals are irrationally denied their civil rights on the basis of pejorative connotations derived from diagnostic or descriptive terminology used in psychiatry and deplores all such discrimination. This resolution singles out discrimination against homosexuals only because of the pervasive discriminatory acts directed against this group and the arbitrary and discriminatory laws directed against homosexual behavior).

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1973_HomosexualityCivilRights.pdf

Statement on discrimination based on gender or sexual orientation

Approved by the Board of Trustees, December 1988

Irrational employment discrimination on the basis of gender and sexual orientation has received considerable attention in law, business, sociology, and, to a less degree, psychology. It is well known that sexual harassment and other forms of irrational gender-based employment discrimination are potentially severe occupational stressors. Complaints of sexual harassment and gender-based discrimination have increased in recent years, and this trend is likely to continue because employees are increasingly aware of legal prohibitions against these and other forms of employment discrimination. While the psychiatric needs of self-identified discrimination victims have been underrecognized, both in and out of the workplace, psychiatrists can expect increasing consultations regarding these issues. It is important that psychiatrists appreciate and help others to understand the emotional consequences of irrational employment discrimination based on gender or sexual orientation.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1988_Discrimination.pdf

Homosexuality and the armed services

Approved by the Board of Trustees, December 1990

APA, since 1973, has formally opposed all public and private discrimination against homosexuals in such areas as employment, housing, public accommodations, and licensing. It follows that APA opposes exclusion and dismissal from the armed services on the basis of sexual orientation. Furthermore, APA asserts that no burden of proof of judgment, capacity, or reliability should be placed on homosexuals which is greater than that imposed on any other persons within the armed services.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1990_HomosexualityArmedServices.pdf

Homosexuality and the Immigration and Naturalization Service

Approved by the Board of Trustees, June 1991

The American Psychiatric Association (APA) strongly opposes all public and private discrimination against homosexuals in such areas as employment, housing, public accommodations, licensing, and immigration and nationalization decisions.

Until at least 1990 the U.S. Immigration and Naturalization Service considered homosexuality to be a mental illness and used this determination as a basis for the discriminatory exclusion of homosexual visitors and immigrants to the United States.

APA successfully opposed the continued inclusion of homosexuality as a mental illness by the Immigration and Naturalization Service. The Association believes that physical illness, mental illness, or sexual orientation per se should not be a basis for immigration or naturalization exclusion.

APA welcomes the changes to Title VI of the Immigration and Naturalization Act of 1990 and will be available to contribute to work intended to ensure that the immigration policies and practice of the United States are consistent with the relevant sections of that act.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1991_HomosexualityINS.pdf

Right to Privacy

Approved by the Board of Trustees, June 1991

The American Psychiatric Association (APA) supports the right to privacy in matters such as birth control, reproductive choice, and adult consensual sexual relations conducted in private, and it supports legislative, judicial, and regulatory efforts to protect and guarantee this right.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps1991_RightPrivacy.pdf

Sexual orientation, therapies focused on attempts to change (reparative or conversion therapies)

Approved by the Board of Trustees, March 2000

Approved by the Assembly, May 2000

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships. In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such an integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged. To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims. Even though there are little data about patients, it is still possible to evaluate the theories which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both. In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologize homosexuality with traditional religious beliefs condemning homosexuality.

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers. Later, criticisms emerged from psychoanalytic sources as well. There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2000_ReparativeTherapy.pdf

Adoption and Co-parenting of children by same-sex couples [EXCERPTED]

Approved by the Board of Trustees, November 2002

Approved by the Assembly, November 2002

The American Psychiatric Association supports initiatives which allow same-sex couples to adopt and coparent children and supports all the associated legal rights, benefits, and responsibilities which arise from such initiatives.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2002_Adoption.pdf

Same sex unions

Approved by the Board of Trustees, December 2004

Approved by the Assembly, November 2004

The American Psychiatric Association supports the legal recognition of same-sex unions and their associated legal rights, benefits, and responsibilities, and opposes restrictions to those same rights, benefits, and responsibilities.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2005_SameSexUnions.pdf

Support of legal recognition of same-sex civil marriage

Approved by the Board of Trustees, July 2005

Approved by the Assembly, May 2005

In the interest of maintaining and promoting mental health, the American Psychiatric Association supports the legal recognition of same-sex civil marriage with all rights, benefits, and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2005_SameSexMarriage.pdf

Position Statement on Homosexuality

Approved by the Board of Trustees, December 1992; Reaffirmed, July 2011

Whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, the American Psychiatric Association (APA) calls on all international health organizations, psychiatric organizations, and individual psychiatrists in other countries to urge the repeal in their own countries of legislation that penalizes homosexual acts by consenting adults in private. Further, APA calls on these organizations and individuals to do all that is possible to decrease the stigma related to homosexuality wherever and whenever it may occur.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2011_Homosexuality.pdf

Transgender and gender variant individuals, Access to care for [EXCERTPED]

Approved by the Board of Trustees, July 2012

Approved by the Assembly, May 2012

The American Psychiatric Association:

1. Supports laws that protect the civil rights of transgender and gender variant individuals.
2. Urges the repeal of laws and policies that discriminate against transgender and gender variant individuals.
3. Opposes all public and private discrimination against transgender and gender variant individuals in such areas as health care, employment, housing, public accommodation, education, and licensing.
4. Declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf

Transgender and gender variant individuals, Discrimination against [EXCERPTED]

Approved by the Board of Trustees, July 2012

Approved by the Assembly, May 2012

The American Psychiatric Association:

1. Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments.
2. Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.
3. Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderDiscrimination.pdf

[Back to Top](#)

American Psychological Association

Discrimination Against Homosexuals

Adopted by the APA Council of Representatives on January 24-26, 1975

1. The American Psychological Association supports the action taken on December 15, 1973, by the American Psychiatric Association, removing homosexuality from that Association's official list of mental disorders. The American Psychological Association therefore adopts the following resolution:

Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities; Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations.

2. Regarding discrimination against homosexuals, the American Psychological Association adopts the following resolution concerning their civil and legal rights:

The American Psychological Association deplors all public and private discrimination in such areas as employment, housing, public accommodation, and licensing against those who engage in or have engaged in homosexual activities and declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons. Further, the American Psychological Association supports and urges the enactment of civil rights legislation at the local, and state and federal level that would offer citizens who engage in acts of homosexuality the same protections now guaranteed to others on the basis of race, creed, color, etc. Further, the American Psychological Association supports and urges the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private.

<http://www.apa.org/about/policy/discrimination.aspx>

Child Custody or Placement

Adopted by the APA Council of Representatives on September 2 & 5, 1976

The sex, gender identity, or sexual orientation of natural, or prospective adoptive or foster parents should not be the sole or primary variable considered in custody or placement cases.

<http://www.apa.org/about/policy/custody-placement.aspx>

Employment Rights of Gay Teachers

Adopted by the APA Council of Representatives on January 23-25, 1981

Whereas the American Psychological Association deplors all public and private discrimination in such areas as employment, housing, public accommodation, and licensing against those who engage in or have engaged in homosexual activities and declares that no burden of proof of such judgement, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other person;

Be it resolved that the American Psychological Association protests personnel actions against any teacher solely because of sexual orientation or affectional preference (Abeles, 1981, p. 581).

<http://www.apa.org/about/policy/employment.aspx>

Hate Crimes

Originally adopted by the American Psychological Association Council of Representatives on August 27 & 30, 1987. Revised February 18-20, 2005.

Whereas the experience of criminal and violent victimization has profound psychological consequences; and

Whereas the frequency and severity of crimes and violence manifesting prejudice have been documented; and

Whereas the American Psychological Association opposes prejudice and discrimination based upon race, ethnicity, religion, sexual orientation, gender, gender identity, or physical condition;

Therefore be it resolved that the American Psychological Association condemns harassment, violence, and crime motivated by such prejudice;

Be it further resolved that the American Psychological Association encourages researchers, clinicians, teachers, and policy-makers to help reduce and eliminate hate crimes and bias-related violence and to alleviate their effects upon the victims, particularly those victims who are children, youth, and elderly;

Be it further resolved that the American Psychological Association supports government's collection and publication of statistics on hate crimes and bias-related violence, provision of services for victims and their loved ones, and interventions to reduce and eliminate such crimes and violence, and policies that perpetuate them.

<http://www.apa.org/about/policy/hate-crimes.aspx>

Use of Diagnoses “Homosexuality” & “Ego-Dystonic Homosexuality”

Adopted by the APA Council of Representatives on August 27 & 30, 1987

Whereas the American Psychological Association has been on record since 1975 that “homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities”; and

Whereas it appears that the ICD-9-CM is widely used either by mandate or choice by many psychologists nationwide in connection with third-party reimbursement, institutional-based service delivery, and research; and

Whereas the next revision of the ICD is not anticipated to be completed until 1992 and may, according to current proposals, then contain the “ego-dystonic homosexuality” diagnosis which APA also opposes; and

Whereas the Council of Representatives already has urged APA members not to use the proposed DSM-III-R diagnoses of Periluteal Phase Disorder, Self-Defeating Personality Disorder, and Sadistic Personality Disorder because they lack adequate scientific basis and are potentially dangerous to women;

Be it resolved that the American Psychological Association: Urge its members not to use the “302.0 Homosexuality” diagnosis in the current ICD-9-CM or the “302.00 Ego-dystonic Homosexuality” diagnosis in the current DSM-III or future editions of either document.

<http://www.apa.org/about/policy/diagnoses-homosexuality.aspx>

Lesbian, Gay, & Bisexual Youths in the Schools

Adopted by the APA Council of Representatives on February 28, 1993.

Whereas society's attitudes, behaviors, and tendency to render lesbian, gay and bisexual persons invisible permeate all societal institutions including the family and school system (Gonsiorek, 1988; Hetrick & Martin, 1988; Ponse, 1978; Uribe & Harbeck, 1992);

Whereas it is a presumption that all persons, including those who are lesbian, gay, or bisexual, have the right to equal opportunity within all public educational institutions;

Whereas current literature suggests that some youths are aware of their status as lesbian, gay, or bisexual persons by early adolescence (Remafedi, 1987; Savin-Williams, 1990; Slater, 1988; Troiden, 1988);

Whereas many lesbian, gay, and bisexual youths and youths perceived to belong to these groups face harassment and physical violence in school environments (Freiberg, 1987; Hetrick & Martin, 1988; Remafedi, 1987; Schaecher, 1988; Uribe & Harbeck, 1992; Whitlock, 1988);

Whereas many lesbian, gay, and bisexual youths are at risk for lowered self-esteem and for engaging in self-injurious behaviors, including suicide (Hetrick & Martin, 1988; Gonsiorek, 1988; Savin-Williams, 1990; Harry, 1989; Gibson, 1989);

Whereas gay male and bisexual youths are at an increased risk of HIV infection (Savin-Williams, 1992);

Whereas lesbian, gay and bisexual youths of color have additional challenges to their self-esteem as a result of the negative consequences of discrimination based on both sexual orientation and ethnic/racial minority status (Garnets & Kimmel, 1991);

Whereas lesbian, gay and bisexual youths with physical or mental disabilities are at increased risk due to the negative consequence of societal prejudice toward persons with mental or physical disabilities (Pendler & Hingsburger, 1991; Hingsburger & Griffiths, 1986);

Whereas lesbian, gay, and bisexual youths who are poor or working class may face additional risks (Gordon, Schroeder & Abramo, 1990);

Whereas psychologists affect policies and practices within educational environments;

Whereas psychology promotes the individual's development of personal identity including the sexual orientation of all individuals;

Therefore be it resolved that the American Psychological Association and the National Association of School Psychologists shall take a leadership role in promoting societal and familial attitudes and behaviors that affirm the dignity and rights, within educational environments, of all lesbian, gay, and bisexual youths, including those with physical or mental disabilities and from all ethnic/racial backgrounds and classes;

Therefore be it resolved that the American Psychological Association and the National Association of School Psychologists support providing a safe and secure educational atmosphere in which all youths, including lesbian, gay and bisexual youths, may obtain an education free from discrimination, harassment, violence, and abuse, and which promotes an understanding and acceptance of self;

Therefore be it resolved that American Psychological Association and the National Association of School Psychologists encourage psychologists to develop and evaluate interventions that foster nondiscriminatory environments, lower risk for HIV infection, and decrease self-injurious behaviors in lesbian, gay and bisexual youths;

Therefore be it resolved that the American Psychological Association and the National Association of School Psychologists shall advocate efforts to ensure the funding of basic and applied research on and scientific evaluations of interventions and programs designed to address the issues of lesbian, gay, and bisexual youths in the schools, and programs for HIV prevention targeted at gay and bisexual youths;

Therefore be it resolved that the American Psychological Association and the National Association of School Psychologists shall work with other organizations in efforts to accomplish these ends (DeLeon, 1993, p. 782).

<http://www.apa.org/about/policy/schools.aspx>

Appropriate Therapeutic Responses to Sexual Orientation

Adopted by the APA Council of Representatives on August 14, 1997

Whereas societal ignorance and prejudice about same gender sexual orientation put some gay, lesbian, bisexual and questioning individuals at risk for presenting for “conversion” treatment due to family or social coercion and/or lack of information (Haldeman, 1994);

Whereas children and youth experience significant pressure to conform with sexual norms, particularly from their peers;

Whereas children and youth often lack adequate legal protection from coercive treatment;

Whereas some mental health professionals advocate treatments of lesbian, gay, and bisexual people based on the premise that homosexuality is a mental disorder (e.g., Socarides et al, 1997);

Whereas the ethics, efficacy, benefits, and potential for harm of therapies that seek to reduce or eliminate same-gender sexual orientation are under extensive debate in the professional literature and the popular media (Davison, 1991; Haldeman, 1994; Wall Street Journal, 1997);

Therefore, be it resolved that APA affirms the following principles with regard to treatments to alter sexual orientation:

Therefore, be it resolved that homosexuality is not a mental disorder (American Psychiatric Association, 1973); and

Therefore, be it resolved that psychologists “do not knowingly participate in or condone unfair discriminatory practices” (American Psychological Association, 1992); and

Therefore, be it resolved that “in their work-related activities, psychologists do not engage in unfair discrimination based on ... sexual orientation” (American Psychological Association, 1992); and

Therefore, be it resolved that “in their work-related activities, psychologists respect the rights of others to hold values, attitudes, and opinions that differ from their own.” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists ... respect the rights of individuals to privacy, confidentiality, self-determination and autonomy” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists are aware of cultural, individual and role differences, including those due to ... sexual orientation” and “try to eliminate the effect on their work of biases based on [such] factors” (American Psychological Association, 1992); and

Therefore, be it resolved that “where differences of ... sexual orientation ... significantly affect psychologist's work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists do not make false or deceptive statements concerning ... the scientific or clinical basis for ... their services,” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists attempt to identify situations in which particular interventions ... may not be applicable ... because of factors such as ... sexual orientation” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists obtain appropriate informed consent to therapy or related procedures” [which] “generally implies that the [client or patient] (1) has the capacity to consent, (2) has been informed of significant information concerning the procedure, (3) has freely and without undue influence expressed consent, and (4) consent has been appropriately documented” (American Psychological Association, 1992); and

Therefore, be it resolved that “when persons are legally incapable of giving informed consent, psychologists obtain informed permission from a legally authorized person, if such substitute consent is permitted by law” (American Psychological Association, 1992);

Therefore, be it resolved that “psychologists (1) inform those persons who are legally incapable of giving informed consent about the proposed interventions in a manner commensurate with the persons' psychological capacities, (2) seek their assent to those interventions, and (3) consider such persons' preferences and best interests” (American Psychological Association, 1992); and

Therefore, be it resolved that the American Psychological Association “urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientation” (Conger, 1975, p. 633); and

Therefore, be it further resolved that the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation.

<http://www.apa.org/about/policy/appropriate.aspx>

Sexual Orientation & Marriage

Adopted by the APA Council of Representatives July 28 & 30, 2004. Reaffirmed by Council Aug. 11 & 15, 2010.

Whereas APA has a long-established policy to deplore "all public and private discrimination against gay men and lesbians" and urges "the repeal of all discriminatory legislation against lesbians and gay men" (Conger, 1975, p. 633);

Whereas the APA adopted the Resolution on Legal Benefits for Same-Sex Couples in 1998 (Levant, 1998, pp. 665-666);

Whereas discrimination and prejudice based on sexual orientation detrimentally affect psychological, physical, social, and economic well-being (Badgett, 2001; Cochran, Sullivan, & Mays, 2003; Herek, Gillis, & Cogan, 1999; Meyer, 2003);

Whereas "anthropological research on households, kinship relationships, and families, across cultures and through time, provide[s] no support whatsoever for the view that either civilization or viable social orders depend upon marriage as an exclusively heterosexual institution" (American Anthropological Association, 2004);

Whereas psychological research on relationships and couples provides no evidence to justify discrimination against same-sex couples (Kurdek, 2001, 2004; Peplau & Beals, 2004; Peplau & Spalding, 2000);

Whereas the institution of civil marriage confers a social status (Donovan, 2003; Goodridge v. Dep't of Public Health, 2003; Johnson, 2000; Kujovich, 2000; Maynard v. Hill, 1888; Turner v. Safley, 1987) and important legal benefits, rights, and privileges (Baehr v. Lewin, 1993; Baker v. State, 1999; Goodridge v. Dep't of Public Health, 2003);

Whereas the United States General Accounting Office (2004) has identified over 1,000 federal statutory provisions in which marital status is a factor in determining or receiving benefits, rights, and privileges, for example, those concerning taxation, federal loans, and dependent and survivor benefits (e.g., Social Security, military, and veterans);

Whereas there are numerous state, local, and private sector laws and other provisions in which marital status is a factor in determining or receiving benefits, rights, and privileges, for example, those concerning taxation, health insurance, health care decision-making, property rights, pension and retirement benefits, and inheritance (Baehr v. Lewin, 1993; Baker v. State, 1999; Goodridge v. Dep't of Public Health, 2003);

Whereas same-sex couples are denied equal access to civil marriage (Eskridge, 1999);

Whereas same-sex couples who enter into a civil union are denied equal access to all the benefits, rights, and privileges provided by federal law to married couples (United States General Accounting Office, 2004) (Eskridge, 2001; Recent Legislation, Act Relating to Civil Unions, 2001; Strasser, 2000);

Whereas the benefits, rights, and privileges associated with domestic partnerships are not universally available (Allison, 2003), are not equal to those associated with marriage (Shin, 2002; Strasser, 2002), and are rarely portable (Shin, 2002; Strasser, 2002);

Whereas people who also experience discrimination based on age, race, ethnicity, disability, gender and gender identity, religion, and socioeconomic status may especially benefit from access to marriage for same-sex couples (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients, 2000);

Therefore be it resolved that the APA believes that it is unfair and discriminatory to deny same-sex couples legal access to civil marriage and to all its attendant benefits, rights, and privileges;

Therefore be it further resolved that APA shall take a leadership role in opposing all discrimination in legal benefits, rights, and privileges against same-sex couples;

Therefore be it further resolved that APA encourages psychologists to act to eliminate all discrimination against same-sex couples in their practice, research, education and training (American Psychological Association, 2002);

Therefore be it further resolved that the APA shall provide scientific and educational resources that inform public discussion and public policy development regarding sexual orientation and marriage and that assist its members, divisions, and affiliated state, provincial, and territorial psychological associations.

<http://www.apa.org/about/policy/marriage.aspx>

Sexual Orientation & Military Service

Adopted by the APA Council of Representatives July 28 & 30, 2004.

Whereas the American Psychological Association (APA) has long opposed discrimination on the basis of sexual orientation; and

Whereas the “Don’t Ask, Don’t Tell, Don’t Pursue” policy as mandated by Title 10 of the U.S. Code (Section 654) discriminates on the basis of sexual orientation, and has caused many qualified personnel to be involuntarily separated from military service solely because of their sexual orientation; and

Whereas in light of the enactment of 10 USC § 654 in 1994, APA’s 1991 resolution U.S Department of Defense Policy on Sexual Orientation and Advertising in APA Publications needs to be revised; and

Whereas there is a long history of collaboration between psychology and the military (Dunivin, 1994; Yerkes, 1921); and

Whereas the law creates ethical dilemmas for military psychologists and it is APA’s responsibility to address these concerns (American Psychological Association, 2002); and

Whereas empirical evidence fails to show that sexual orientation is germane to any aspect of military effectiveness including unit cohesion, morale, recruitment and retention (Belkin, 2003; Belkin & Bateman, 2003; Herek, Jobe, & Carney, 1996; MacCoun, 1996; National Defense Research Institute, 1993); and

Whereas comparative data from foreign militaries and domestic police and fire departments show that when lesbians, gay men and bisexuals are allowed to serve openly there is no

evidence of disruption or loss of mission effectiveness (Belkin & McNichol, 2000-2001; Gade, Segal, & Johnson, 1996; Koegel, 1996); and

Whereas when openly gay, lesbian and bisexual individuals have been allowed to serve in the U.S. Armed Forces (*Cammermeyer v. Aspin*, 1994; *Watkins v. United States Army*, 1989/1990), there has been no evidence of disruption or loss of mission effectiveness; and

Whereas the U.S. military is capable of integrating members of groups historically excluded from its ranks, as demonstrated by its success in reducing both racial and gender discrimination (Binkin & Bach, 1977; Binkin, Eitelberg, Schexnider, & Smith, 1982; Kauth & Landis, 1996; Landis, Hope, & Day, 1984; Thomas & Thomas, 1996);

Therefore be it resolved that APA reaffirms its opposition to discrimination based on sexual orientation; and

Be it further resolved that APA reaffirms its support for our men and women in uniform and its dedication to promoting their health and well-being; and

Be it further resolved that APA recognizes and abhors the many detrimental effects that the law has had on individual service members, the military, and American society since its enactment in 1994; and

Be it further resolved that APA take a leadership role among national organizations in seeking to eliminate discrimination in and by the military based on sexual orientation through federal advocacy and all other appropriate means; and

Be it further resolved that APA act to ameliorate the negative effects of the current law through the training and education of psychologists; and

Be it further resolved that APA disseminate scientific knowledge and professional expertise relevant to implementing this resolution; and

Be it further resolved that this resolution replaces the 1991 resolution “U.S. Department of Defense Policy on Sexual Orientation and Advertising in APA Publications;” and

Be it further resolved that APA reaffirms its strong commitment to removing the stigma of mental illness that has long been associated with homosexual and bisexual behavior and orientations; promoting the health and well-being of lesbian, gay, and bisexual adults and youth; eliminating violence against lesbian, gay, and bisexual service members; and working to ensure the equality of lesbian, gay, and bisexual people, both as individuals and members of committed same-sex relationships, in such areas as employment, housing, public accommodation, licensing, parenting, and access to legal benefits.

<http://www.apa.org/about/policy/military.aspx>

Sexual Orientation, Parents, & Children

Adopted by the APA Council of Representatives July 28 & 30, 2004.

Whereas APA supports policy and legislation that promote safe, secure, and nurturing environments for all children (DeLeon, 1993, 1995; Fox, 1991; Levant, 2000);

Whereas APA has a long-established policy to deplore "all public and private discrimination against gay men and lesbians" and urges "the repeal of all discriminatory legislation against lesbians and gay men" (Conger, 1975);

Whereas the APA adopted the Resolution on Child Custody and Placement in 1976 (Conger, 1977, p. 432)

Whereas discrimination against lesbian and gay parents deprives their children of benefits, rights, and privileges enjoyed by children of heterosexual married couples;

Whereas some jurisdictions prohibit gay and lesbian individuals and same-sex couples from adopting children, notwithstanding the great need for adoptive parents (Lofton v. Secretary, 2004);

Whereas there is no scientific evidence that parenting effectiveness is related to parental sexual orientation: lesbian and gay parents are as likely as heterosexual parents to provide supportive and healthy environments for their children (Patterson, 2000, 2004; Perrin, 2002; Tasker, 1999);

Whereas research has shown that the adjustment, development, and psychological well-being of children is unrelated to parental sexual orientation and that the children of lesbian and gay parents are as likely as those of heterosexual parents to flourish (Patterson, 2004; Perrin, 2002; Stacey & Biblarz, 2001);

Therefore be it resolved that the APA opposes any discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care, and reproductive health services;

Therefore be it further resolved that the APA believes that children reared by a same-sex couple benefit from legal ties to each parent;

Therefore be it further resolved that the APA supports the protection of parent-child relationships through the legalization of joint adoptions and second parent adoptions of children being reared by same-sex couples;

Therefore be it further resolved that APA shall take a leadership role in opposing all discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care, and reproductive health services;

Therefore be it further resolved that APA encourages psychologists to act to eliminate all discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care, and reproductive health services in their practice, research, education and training (American Psychological Association, 2002);

Therefore be it further resolved that the APA shall provide scientific and educational resources that inform public discussion and public policy development regarding discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care, and reproductive health services and that assist its members, divisions, and affiliated state, provincial, and territorial psychological associations.

<http://www.apa.org/about/policy/parenting.aspx>

Resolution on Opposing Discriminatory Legislation & Initiatives Aimed at Lesbian, Gay & Bisexual Persons

Adopted by the APA Council of Representatives on February 16-18, 2007

Whereas various states and other jurisdictions have enacted legislation and/or constitutional amendments that limit the access of same-sex couples to the legal rights and responsibilities of marriage and that therefore affect their relationships with each other and/or with their children;

Whereas various states and other jurisdictions have enacted legislation and/or constitutional amendments that limit legal recourse available to lesbians, gay men and bisexual people in the face of discrimination based on sexual orientation;

Whereas it has been the expressed or implied intent of some elected and appointed officials to apply these laws in a manner that selectively discriminates against lesbians, gay men and bisexual people (e.g., Davidoff, 2006);

Whereas these legal restrictions resist the force of psychological data that provide "no evidence to justify discrimination against same-sex couples" (Paige, 2005a, p. 2);

Whereas these legal restrictions contradict two decades of empirical research that suggests "that the development, adjustment, and well-being of children with lesbian and gay parents do not differ markedly from that of children with heterosexual parents" (Paige, 2005b, p. 2);

Whereas the debate leading up to these legal enactments as well as their outcome cause undue psychological risk to same-sex couples and their children as well as to single lesbian, gay and bisexual individuals, and they create a hostile climate for all lesbian, gay and bisexual people (Bullis & Bach, 1996; Davies, 1982; Donovan & Bowler, 1997; Douglass, 1997; Eastland, 1996a, 1996b; Gonsiorek, 1993; McCorkle & Most, 1997; Moritz, 1995; Moses-Zirkes, 1993; Russell, 2000; Russell & Richards, 2003; Smith, 1997; Whillock, 1995);

Whereas the psychological risks associated with exposure to prejudice and discrimination result in increased psychological distress (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; DiPlacido, 1998; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001; Mays & Cochran, 2001; Meyer, 2003; Russell, 2000; Russell & Richards, 2003);

Whereas APA has taken clear stands against discrimination in any of its forms and against discrimination against lesbians, gay men and bisexual people in particular (Conger, 1975);

Whereas current immigration law unfairly discriminates against same-sex couples when one is a U.S. citizen and the partner is not;

Whereas municipal laws that prohibit or otherwise limit households members who are not related by biology or marriage may unfairly affect same-sex couples, who typically lack access to marriage, as well as poor people and other-sex partners who do not choose to marry;

Whereas APA has policies that specifically oppose discrimination against same-sex couples in access to marriage (Paige, 2005a) and that oppose "any discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care and reproductive health services" (Paige, 2005b, p. 3);

Whereas APA is increasingly adopting an international focus and lesbian, gay, bisexual and transgender people in many parts of the world face hostile environments;

Therefore be it resolved that APA reaffirms its opposition to discrimination against lesbians, gay men and bisexual people and will take a leadership role in actively opposing the adoption of discriminatory legislation and initiatives;

Be it further resolved that APA will convene a meeting of representatives of national health and mental health organizations to encourage their opposition to legislation and initiatives that discriminate on the basis of sexual orientation;

Be it further resolved that APA shall consider the nature of the public policy with regard to sexual orientation discrimination of states and other jurisdictions as one relevant factor when making decisions about meetings and other contractual agreements;

Be it further resolved that APA shall take reasonable steps to publicly oppose discriminatory policies and to promote the physical and psychological safety of its members and staff, when holding meetings or engaging in other contractual agreements in states or jurisdictions with public policy that discriminates on the basis of sexual orientation.

Be it further resolved that APA encourages psychologists to act to oppose public policy that discriminates on the basis of sexual orientation;

Be it further resolved that the APA shall provide scientific and educational resources that contribute to the public debate over sexual orientation discrimination and that assist APA members, divisions, and affiliated state, provincial, and territorial psychological associations to participate in the public debate.

Be it further resolved that APA encourages the United States National Committee for Psychology to develop and recommend to the International Union of Psychological Science General Assembly an international policy for psychology on sexual orientation discrimination;

Be it further resolved that APA encourages the United States to enact immigration laws that allow same-sex couples in which one is a citizen and one is not access to the same rights, privileges, and responsibilities that apply to other-sex couples in which one is a U.S. citizen and the partner is not;

Be it finally resolved that APA encourages municipalities to abolish laws that prohibit or otherwise limit households whose members are not related by biology or marriage that unfairly affect same-sex couples, who typically lack access to marriage, as well as poor people and other-sex partners who do not choose to marry.

<http://www.apa.org/about/policy/discriminatory-legislation.aspx>

Transgender, Gender Identity, & Gender Expression Non-Discrimination

Adopted by the American Psychological Association Council of Representatives August, 2008.

Whereas transgender and gender variant people frequently experience prejudice and discrimination and psychologists can, through their professional actions, address these problems at both an individual and a societal level;

Whereas the American Psychological Association opposes prejudice and discrimination based on demographic characteristics including gender identity, as reflected in policies including the Hate Crimes Resolution (Paige, 2005), the Resolution on Prejudice Stereotypes and Discrimination (Paige, 2007), APA Bylaws (Article III, Section 2), the Ethical Principles of Psychologists and Code of Conduct (APA 2002, 3.01 and Principle E);

Whereas transgender and other gender variant people benefit from treatment with therapists with specialized knowledge of their issues (Lurie, 2005; Rachlin, 2002), and that the Ethical Principles of Psychologists and Code of Conduct state that when scientific or professional knowledge ...is essential for the effective implementation of their services or research, psychologists have or obtain the training....necessary to ensure the competence of their services..." (APA 2002, 2.01b);

Whereas discrimination and prejudice against people based on their actual or perceived gender identity or expression detrimentally affects psychological, physical, social, and economic well-being (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Resolution on Prejudice Stereotypes and Discrimination, Paige, 2007; Riser et al., 2005; Rodriquez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas transgender people may be denied basic non-gender transition related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Riser et al., 2005; Rodriquez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments (De Cuypere et al., 2005; Kuiper &

Cohen-Kettenis, 1988; Lundstrom, et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005);

Whereas gender variant and transgender people may be denied basic civil rights and protections (Minter, 2003; Spade, 2003) including: the right to civil marriage which confers a social status and important legal benefits, rights, and privileges (Paige, 2005); the right to obtain appropriate identity documents that are consistent with a post-transition identity; and the right to fair and safe and harassment-free institutional environments such as care facilities, treatment centers, shelters, housing, schools, prisons and juvenile justice programs;

Whereas transgender and gender variant people experience a disproportionate rate of homelessness (Kammerer et al., 2001), unemployment (APA, 2007) and job discrimination (Herbst et al., 2007), disproportionately report income below the poverty line (APA, 2007) and experience other financial disadvantages (Lev, 2004);

Whereas transgender and gender variant people may be at increased risk in institutional environments and facilities for harassment, physical and sexual assault (Edney, 2004; Minter, 2003; Peterson et al., 1996; Witten & Eyler, 2007) and inadequate medical care including denial of gender transition treatments such as hormone therapy (Edney, 2004; Peterson et al., 1996; Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas many gender variant and transgender children and youth face harassment and violence in school environments, foster care, residential treatment centers, homeless centers and juvenile justice programs (D'Augelli, Grossman, & Starks, 2006; Gay Lesbian and Straight Education Network, 2003; Grossman, D'Augelli, & Slater, 2006);

Whereas psychologists are in a position to influence policies and practices in institutional settings, particularly regarding the implementation of the Standards of Care published by the World Professional Association of Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association) which recommend the continuation of gender transition treatments and especially hormone therapy during incarceration (Meyer et al., 2001);

Whereas psychological research has the potential to inform treatment, service provision, civil rights and approaches to promoting the well-being of transgender and gender variant people;

Whereas APA has a history of successful collaboration with other organizations to meet the needs of particular populations, and organizations outside of APA have useful resources for addressing the needs of transgender and gender variant people;

Therefore be it resolved that APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

Therefore be it further resolved that APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

Therefore be it further resolved that APA supports full access to employment, housing, and education regardless of gender identity and expression;

Therefore be it further resolved that APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals;

Therefore be it further resolved that APA encourages legal and social recognition of transgender individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression which do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

Therefore be it further resolved that APA supports access to civil marriage and all its attendant benefits, rights, privileges and responsibilities, regardless of gender identity or expression;

Therefore be it further resolved that APA supports efforts to provide fair and safe environments for gender variant and transgender people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

Therefore be it further resolved that APA supports efforts to provide safe and secure educational environments, at all levels of education, as well as foster care environments and juvenile justice programs, that promote an understanding and acceptance of self and in which all youths, including youth of all gender identities and expressions, may be free from discrimination, harassment, violence, and abuse;

Therefore be it further resolved that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals;

Therefore be it further resolved that APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

Therefore be it further resolved that APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender transition therapies;

Therefore be it further resolved that APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender;

Therefore be it further resolved that APA supports the funding of basic and applied research concerning gender expression and gender identity;

Therefore be it further resolved that APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development, and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals regardless of gender identity or gender expression;

Therefore be it further resolved that APA supports cooperation with other organizations in efforts to accomplish these ends.

<http://www.apa.org/about/policy/transgender.aspx>

Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

Adopted by the APA Council of Representatives on August 5, 2009.

Whereas the American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (American Psychological Association, 1998, 2000, 2002, 2003, 2005, 2006, 2008b);

Whereas the American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008b);

Whereas psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or non-religious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b);

Whereas psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008b);

Whereas those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008b);

Whereas the American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when

such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008b);

Whereas societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

Whereas some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968);

Whereas sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997), who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciotto & Cahill, 2006; Ryan & Futterman, 1997); and

Whereas research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hershberger & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

Therefore be it resolved that the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

Be it further resolved that the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

Be it further resolved that the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

Be it further resolved that the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

Be it further resolved that the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

Be it further resolved that the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a

foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren & Prince, 2004; Ryan & Futterman, 1997; Norcross, 2002);

Be it further resolved that the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

Be it further resolved that the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (American Psychological Association, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity;

Be it further resolved that the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma, and contribute to variations in sexual orientation identity development, expression, and experience;

Be it further resolved that the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

Be it further resolved that the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

Be it further resolved that the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policy makers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the wellbeing of sexual minorities.

<http://www.apa.org/about/policy/sexual-orientation.aspx>

Resolution on Marriage Equality for Same-Sex Couples

Adopted by the APA Council of Representatives on August 3-5, 2011.

Whereas people benefit by sharing their lives with and receiving support from their family, friends, and other people who are important to them (Cohen & Wills, 1985);

Whereas a person's sexual orientation defines the universe of persons with whom he or she is likely to find the satisfying and fulfilling romantic and intimate relationships that, for many

individuals, comprise an essential component of personal identity (D'Augelli, 2000; Gonsiorek & Weinrich, 1991; Herek, 2001, 2006; Peplau & Garnets, 2000);

Whereas homosexuality is a normal expression of human sexual orientation that poses no inherent obstacle to leading a happy, healthy, and productive life, including the capacity to form healthy and mutually satisfying intimate relationships with another person of the same sex and to raise healthy and well-adjusted children, as documented by several professional organizations (American Psychiatric Association, 1974; American Psychological Association, 2004a, 2004b; Conger, 1975, National Association of Social Workers, 2003);

Whereas many gay men and lesbians, like their heterosexual counterparts, desire to form stable, long-lasting, and committed intimate relationships and are successful in doing so (Gates, 2006; Henry J. Kaiser Family Foundation, 2001; Herek, Norton, Allen, & Sims 2010; Peplau & Fingerhut, 2007; Simmons & O'Connell, 2003);

Whereas the consideration of policies to provide or deny same-sex couples full access to civil marriage and other legal forms of family formation in all branches of both the federal and state governments in the United States has frequently subjected the human rights of lesbian, gay, and bisexual people to public debate and resulted in wide variation among jurisdictions in access to these rights (Gates, Badgett, & Ho, 2008; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Herek, 2006; National Gay and Lesbian Task Force, 2010; Rostosky, Riggle, & Horne 2009; Russell, 2000);

Whereas emerging evidence suggests that statewide campaigns to deny same-sex couples legal access to civil marriage are a significant source of stress to the lesbian, gay, and bisexual residents of those states and may have negative effects on their psychological well-being (Hatzenbuehler et al., 2010; Rostosky et al., 2009);

Whereas the denial of civil marriage, including the creation of legal statuses such as civil unions and domestic partnerships, stigmatizes same-sex relationships, perpetuates the stigma historically attached to homosexuality, and reinforces prejudice against lesbian, gay, and bisexual people (Badgett, 2009; Herek, 2006; Hull, 2006);

Whereas many gay, lesbian, and bisexual adults who are in a committed same-sex relationship have taken advantage of the right to marriage, either in their home jurisdictions or in other jurisdictions, even though many jurisdictions that do not permit marriage of same-sex couples do not recognize these valid marriages (Badgett, 2009; Gates et al., 2008; Herel, Marech, & Lechuk, 2004; Marech, 2004);

Whereas many other adults who are in a committed same-sex relationship wish to marry, but are prevented by state law from being married in their home jurisdiction or from receiving recognition of their marriages performed elsewhere (Herek et al., 2010);

Whereas empirical research demonstrates that the psychological and social aspects of committed relationships between same-sex partners closely resemble those of heterosexual partnerships, and an emerging research literature suggests that legally recognized same-sex relationships may also be similar to heterosexual marriages in these psychological and social

aspects (Balsam, Beauchaine, Rothblum, & Solomon, 2008; Kurdek, 2004, 2005; Peplau & Fingerhut, 2007);

Whereas married individuals generally receive social, economic, health, and psychological benefits from their marital status, including numerous rights and benefits provided by private employers and by state and federal governments (Badgett, 2001; Brown, 2000; Chauncey 2005; Gove, Hughes, & Style, 1983; Gove, Style, & Hughes, 1990; Kiecolt-Glaser, 2001; Murray, 2000; Ross, Mirowsky, Goldsteen, 1990; Stack & Eshleman, 1998; Williams, 2003;

Whereas all people can be adversely affected by high levels of stress and the link between experiencing stress and manifesting symptoms of psychological or physical illness is well established in human beings and other species (Cohen, Doyle, & Skoner, 1999; Dohrenwend, 2000); Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002);

Whereas individuals with a homosexual or bisexual orientation are often subjected to minority stress, that is, additional stress beyond what is normally experienced by the heterosexual population, as a consequence of stigma, discrimination, and violence (Badgett, 2001; Berrill, 1992; Herek, 2009; Herek, Gillis, Cogan, 1999; Mays & Cochran, 2001; Meyer, 1995; 2003; Meyer, Schwartz, & Frost, 2008);

Whereas the experience of minority stress may create somewhat higher levels of illness or psychological distress in the sexual minority population, compared to the heterosexual population (Herek & Garnets, 2007; Mays & Cochran, 2001; Meyer, 1995; 2003);

Whereas minority stress is common to all minority groups that experience stressors due to prejudice and discrimination based on their minority status (Meyer, 2003);

Whereas lesbian, gay, and bisexuals with multiple minority statuses (e.g., people of color, persons with disabilities) often experience a dual minority stress that may negatively impact their mental health (Crawford, Allison, Zamboni, & Soto, 2002; Green, 1994; Harley, Nowak, Gassaway, & Savag, 2002).

Whereas policies supportive of lesbian, gay, and bisexual people's human rights may have positive effects on their psychological well-being (Blake, Ledsky, Lehman, Goodenow, Sawyer, Hack, 2001; Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, Keyes, Hasin, 2009);

Therefore be it resolved that the American Psychological Association supports full marriage equality for same-sex couples;

Be it further resolved that the American Psychological Association reiterates its opposition to ballot measures, statutes, constitutional amendments, and other forms of discriminatory policy aimed at limiting lesbian, gay, and bisexual people's access to legal protections for their human rights, including such measures as those that deny same-sex couples the right to marry (Conger, 1975, APA 2007);

Be it further resolved that the American Psychological Association calls on state governments to repeal all measures that deny same-sex couples the right to civil marriage and to enact laws to provide full marriage equality to same-sex couples;

Be it further resolved that the American Psychological Association calls on the federal government to extend full recognition to legally married same-sex couples, and to accord them all of the rights, benefits, and responsibilities that it provides to legally married different-sex couples;

Be it further resolved that the American Psychological Association encourages psychologists and other behavioral scientists to conduct quality research that extends our understanding of the lesbian, gay, and bisexual population, including the role of close relationships and family formation on the health and well-being of lesbian, gay, and bisexual adults and youths;

Be it further resolved that the American Psychological Association encourages psychologists and other professionals with appropriate knowledge to take the lead in developing interventions and in educating the public to reduce prejudice and discrimination and to help ameliorate the negative effects of stigma;

Be it further resolved that the American Psychological Association will work with government and private funding agencies to promote such research and interventions to improve the health and well-being of lesbian, gay, and bisexual people.

<http://www.apa.org/about/policy/same-sex.aspx>

[Back to Top](#)

American Public Health Association

Homosexuality and Public Health [EXCERTED]

Policy Date: 1/1/1975

Policy Number: 7514

Be It Resolved that the American Public Health Association deplors all public and private discrimination against persons with homosexual orientation in such areas as employment, education, licensing, housing, credit, public accommodation, worship, social welfare, and health services, and declares that no burden of proof of judgment, reliability, ethicality, capability, or entitlement shall be placed upon such persons which is greater or different than that placed upon other persons; and

Be It Further Resolved that APHA supports the enactment of civil rights laws at the local, state and federal levels which would provide to persons with homosexual orientation the same protections now provided to others on the basis of religion, color, sex, etc., and, in particular, endorses H.R. 5452, a Bill "to prohibit discrimination on the basis of affectional or sexual preference" introduced into the 94th Congress by Representative Bella Abzug and others; and

Be It Further Resolved that APHA supports the repeal of laws which classify as criminal conduct consensual sexual activity of any form in private, saving only those portions which protect children, the mentally incompetent, and other helpless persons from rape and other forced sexual activity; and

Be It Further Resolved that APHA will include discrimination on the basis of sexual orientation among the prohibited discriminations in its own policies regarding equal employment opportunity for its own staff and for its employment service, and urges all health agencies to do likewise; and

Be It Further Resolved that APHA urges all health agencies which engage in educational activities for their own staffs and for other health workers to provide education regarding the adverse effects of homophobia on the health of the people and regarding ways for health workers to respond better to the needs of patients with homosexual orientation; and

Be It Further Resolved that APHA requests the Public Health Service, U.S. Department of Health, Education, and Welfare to study, with the assistance of knowledgeable gay persons, the problems encountered by homosexually oriented persons both when receiving and providing health care.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=792>

The Need for Public Health Research on Gender Identity and Sexual Orientation

Policy Date: 1/1/1998

Policy Number: 9819

The American Public Health Association, being aware that health problems cannot be solved without adequate research that explores the behavioral, cultural, social, and etiologic aspects

of the problem; and recognizing that the incidence and prevalence of diseases such as cancers, hepatitis B, substance abuse, suicide risk, eating disorders, HIV (human immunodeficiency virus), sexually transmitted diseases, and interpersonal violence may be affected by sexual orientation and behavior, and gender identity; and realizing that lesbians, gay men, bisexuals, and transsexual people may not see themselves at risk for many health problems and that health care providers may not identify and successfully diagnose them resulting in inadequate treatment; and knowing that health problems may affect these populations differently because of economic or marital status, racial, ethnic, age, gender, place of residence and educational factors; and recognizing that homophobia and discrimination against transgender populations may have adverse public health consequences; and concluding that educational, research, and funding institutions need to support major research initiatives to address these health problems; therefore

5. Urges funders of health research to strongly encourage their sponsored special population-based research to gather data on the sexual orientation of their populations when such data is scientifically justifiable;
6. Urges the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to support new research initiatives to understand sexual orientation and gender identity, the prevalence and incidence of disease associated with the population, and specific health and access to care problems; and
7. Urges private and public funding agencies and educational institutions to support the development of scientists interested in doing research on sexual orientation and sexual identity issues by awarding grants to first-time researchers in the field, providing post-doctoral fellowships for research in the field, awarding funds for travel to meetings, and supporting graduate students.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=171>

The Need for Acknowledging Transgendered Individuals within Research and Clinical Practice

Policy Date: 1/1/1999

Policy Number: 9933

The American Public Health Association, realizing that transgender refers to a population of individuals who do not and/or cannot conform to traditional norms of gender, for example:

- **Transgender:** Transgender is an umbrella term used to describe the full range of individuals who do not necessarily conform to society's standards of gender and sex; and incorporate one or more aspects, traits, social roles or characteristics of the other gender.
- **FTM:** Common abbreviation denoting a female-to-male transgendered/transsexual. This term can cover many forms of gender expression of the individual.
- **MTF:** Common abbreviation denoting a male-to-female transgendered/transsexual. This term can cover many forms of gender expressions of the individual.
- **Transsexual:** An individual who actively seeks to change or has changed his/her body through hormonal reassignment and/or various surgical procedures.

- Transvestite/Cross-dresser: One who wears the clothing and cultivates the appearance of the other gender. This word has a few different meanings. In its purest form, transvestitism means "Cross-dressing."
- Intersexed: Anatomic sex differentiation occurs on a male/female continuum, and there are several dimensions. Genetic sex, or the organization of the "sex chromosomes," is commonly thought to be isomorphic to some idea of "true sex." The sex chromosomes determine the differentiation of the gonads into ovaries, testes, ovo-testes, or nonfunctioning streaks. The hormones produced by the fetal gonads determine the differentiation of the external genitalia into male, female, or intermediate (intersexual) morphology; * and

Understanding that transgendered individuals vary by age, race, culture, income, education, residence, sexual orientation, marital status, religion, ability/disability, immigration status, and interest in medical interventions; and noting that studies generally either do not identify the existence of transgendered individuals, or combine them into a single transgender category and/or misconceptualized under other labels; and acknowledging that little is known about the long term health risks associated with the hormonal and/or surgical reassignment, some of which is conducted without a health care provider's participation, and that studies that do exist have small sample sizes and little generalizability; and noting that medical procedures are conducted upon many children and adolescents with little understanding of their long-term outcome often resulting in pain and distress, and examples of this are that (a) Gender Identity Disorder within the DSM-IV is misused by some health care professionals to treat "pre-homosexual" and "pre-transsexual" children and adolescents so as to promote their development into nontranssexual, heterosexual adults, and (b) genital surgery or sex reassignment surgery are sometimes conducted upon intersexed infants so that their external genitalia resembles that of normal infants; and noting a growing body of literature that finds many transgendered individuals within the United States are at risk of experiencing violence, HIV infections, and many sexually transmitted diseases; and concluding that transgendered individuals are not receiving adequate health care, information, or inclusion within research studies because of discrimination by and/or lack of training of health care providers and researchers; therefore

1. Urges the National Institutes of Health and the Centers for Disease Control and Prevention (as well as individuals researchers and health care workers) to categorize MtF and FtM transgendered individuals as such and not conflate them with gay men or lesbians (unless as appropriate to an individual's sexual orientation in their preferred gender) as well as acknowledging the variation that exists among transgendered individuals;
2. Urges researchers and health care workers to be sensitive to the lives of transgendered individuals and treat them with dignity and respect, and not to force them to fit within rigid gender norms. This includes referring to them as the gender with which they identify;
3. Urges researchers, health care workers, the National Institutes of Health, and the Centers for Disease Control and Prevention to be aware of the distinct health care needs of transgendered individuals; and
4. Urges the National Institutes of Health and the Centers for Disease Control and Prevention to make available resources, including funding for research, that will enable a better understanding of the health risks of transgendered individuals, especially the barriers they experience within health care settings.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=204>

Proposed Resolution Condemning Actions Against Lesbian, Gay, Bisexual, and Transgender (LGBT) and HIV-Related Research and Service Delivery (2004)

Policy Date: 11/9/2004

Policy Number: 2004-10

The leadership of the United States Department of Health and Human Services (DHHS) and some members of Congress have taken actions that will limit the free exchange of scientific information, intimidate researchers and staff at the National Institutes of Health, and create obstacles for those who both write and review applications to receive funding for lesbian, gay, bisexual, and transgender (LGBT)- and human immunodeficiency virus (HIV)-related research and service delivery. Recent actions include, but are not limited to:

- Withholding \$75,000 originally offered for a 2002 conference on Lesbian Health issues that DHHS had supported in;2001
- Removing information on the use of condoms to prevent the spread of HIV and other sexually transmitted infections from the CDC Web site;
- Calling for investigations and defunding of LGBT- and HIV-related research projects by members of Congress;
- Deciding not to support a 2003 United Nations sponsored resolution condemning discrimination based on sexual orientation; and
- Supporting statements made by a Member of Congress equating homosexuality with bestiality.

Whereas the above actions will have the effect of lessening support for LGBT and HIV research, and threatening the health of LGBT people and people with HIV disease.

Whereas the attack on research and programming for LGBT people comes at a time when the previous surgeon general, the American Public Health Association, and other medical and health organizations are calling for increased LGBT research and lessening disparities based on sexual orientation and gender identity.

Whereas research and programs directed toward the health needs of LGBT people and people with HIV disease are now facing the prospect of being disproportionately targeted by federal agencies and losing their funding.

Whereas these activities have created an environment detrimental to LGBT- and HIV-related health research and program development.

Therefore, the American Public Health Association:

Urges Congressional leaders to investigate attempts to undermine the scientific peer-review process at the National Institutes of Health (NIH), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ) and other federal agencies.

Urges the DHHS, the CDC, other federal agencies, and Congress to cease all actions that unfairly jeopardize LGBT- and HIV-related research and service delivery programs.

Urges that DHHS recommit to end health disparities based on sexual orientation and gender identity/expression.

Urges that the president of the United States of America, Congress, and DHHS publicly support the integrity of scientific peer-review processes of all federal agencies.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1296>

Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns [EXCERPTED]

Policy Date: 11/8/2006

Policy Number: 200610

The American Public Health Association urges the following:

1. Efforts to promote abstinence should be provided within public health programs that provide adolescents with complete and accurate information about sexual health. Such programs should be medically accurate and developmentally appropriate, sensitive to cultural diversity and social context, and based on theories and strategies with demonstrated evidence of effectiveness. APHA has strongly supported comprehensive sexuality education that includes information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV and other STIs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods.⁵ Sexuality education should be non-judgmental and support parent-child communication and should not impose religious or ideological viewpoints upon students.
2. States should support school districts and local schools to implement abstinence education as a part of comprehensive sexuality education and as an integral part of comprehensive K-12 school health education.
3. Current federal funding for abstinence-only programs under Section 510 and CBAE should be repealed and replaced with funding for a new federal program to promote comprehensive sexuality education.
4. The U.S. Congress should require that all sexuality education programs supported by the federal government, and all sexual health information disseminated by federal agencies, be medically and scientifically accurate, age and context appropriate, and based on theories and strategies with demonstrated evidence of effectiveness⁵ and consistent with international human rights declarations.
5. Governments and school districts should not tolerate censorship of information related to human sexual health within the public schools.
6. Federally supported public health programs should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered, questioning, and intersexed youth.
7. The federal government should require evaluation of programs to promote abstinence and reduce sexual risk taking. Such evaluations should utilize rigorous

scientific research methods and should assess the behavioral impact as well as outcomes such as STIs and pregnancy. The results of such evaluations should be made available to the public in an expeditious manner.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1334>

Prevention and Control of Sexually Transmitted Infections and HIV among Performers in the Adult Film Industry [EXCERTEED]

Policy Date: 11/9/2010

Policy Number: 20102

Gay Adult Film Industry

The frequent transmission of STDs among heterosexual performers and their outside sexual partners is not a concern for the heterosexual industry only. After the emergence of AIDS in the gay community, the gay adult film industry voluntarily adopted condom use, and, at one point, had condom usage rates much higher than the heterosexual film industry. More recent research has found that the practice of watching adult films in which actors do not use condoms, or “bareback porn,” among men who have sex with men (MSM), is on the rise and that the majority of MSM study participants regularly watched bareback adult films. This is especially concerning, given that STD testing, which is routinely conducted for heterosexual performers, is not commonly practiced among gay performers and it is more likely that gay performers are HIV positive. This study also found a significant, positive relationship between increased viewing of bareback pornography and engagement in unprotected anal intercourse, concluding that bareback pornography may have detrimental health effects not only for performers engaging in its production but also for those who view bareback pornography.

Recommendations

In view of the ongoing, preventable sexual disease transmission in the adult film industry, APHA supports the following measures:

1. State and federal regulatory or legislative actions that would require the employer to (a) provide and require the use of condoms in the production of adult films, (b) provide appropriate medical monitoring, and (c) protect the confidentiality of the worker’s medical record.
2. Requirements that adult film production companies maintain records available for inspection with their Custodian of Record that includes their OSHA-compliant or state plan equivalent exposure control plan, documentation that condoms were used in each production, and documentation that worker medical monitoring and health and safety training was provided.
3. Requirements that adult film production companies provide employment records to OSHA or their state plan equivalent or any state or local health department in the course of any investigation of workplace injury, illness, or transmission or exposure to an infectious disease.
4. Requirements that any clinic or medical provider that provides medical monitoring for an adult film production company collect and provide production company information to OSHA or any state or local health department in the course of any investigation of workplace transmission or exposure to an infectious disease.

5. Mandatory labeling at the beginning of each adult film that states that the adult film was produced pursuant to OSHA or the state-plan equivalent requirements.
6. Prohibition of the distribution and sales of adult films produced in violation of OSHA or the state-plan equivalent requirements to hotels, cable television content providers and others in commercial settings when condoms were not used by performers.
7. Increased federal, state, and local resources that would improve the ability of local health departments, state health departments and OSHA or the state-plan equivalent to investigate and control occupational exposures to infectious diseases and enforce workplace regulations in a timely manner.
8. Vigorous enforcement of OSHA occupational standards to reduce exposure to infectious diseases within the adult film industry.
9. Change through legislation, if necessary, such that the possession of condoms is not cause for arrest or prosecution.

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1396>

[Back to Top](#)