APPENDIX A

GID AND THE TRANSGENDER MOVEMENT

A JOINT STATEMENT BY THE INTERNATIONAL CONFERENCE ON TRANSGENDER LAW AND EMPLOYMENT POLICY (ICTLEP) AND THE NATIONAL CENTER FOR LESBIAN RIGHTS (NCLR)

Gender Identity Disorder (GID) is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA). TransGendered is an inclusive term describing all persons (including transsexual people) within this community. Transsexual people seek to live full-time in the corrected gender role, usually with hormone therapy, name change and gender identification correction on documents and the option of surgical interventions.

The existence of GID as a psychiatric diagnosis raises complicated and important issues. Unfortunately, much of the discussion around these issues has become polarized. In the past two years, both ICTLEP and NCLR (along with other LBGT/lesbigatr – groups) have been criticized by some transsexual activists who fear that we are advocating an immediate and wholesale elimination of GID, without regard for the potential impact on access to hormones and surgeries, reimbursement and other issues. Given the importance of the issues at stake, we want to correct this misconception and to provide those who are interested with a joint statement on GID.

Children and adults have different legal and practical relationships to GID. As minors, children are under the legal power of parents or other adults. Children diagnosed with GID have little or no control over their treatment, which typically consists of behavior modification and counseling to eliminate the child's cross-gender behavior and identification. GID is used to identify so-called "pre-homosexual" and "pre-transsexual" children and youth, with the long-term goal of preventing adulthood transsexualism or homosexuality. Most children diagnosed with GID grow up to be lesbian, gay or bisexual, a smaller number grow up to be transsexual. In addition to the damage inflicted on individual youth, right-wing groups have appropriated the concept that gay and transgendered youth suffer from a psychiatric disorder. These groups are exploiting GID to oppose legal protections for lesbigatr-questioning youth, particularly in public schools, by arguing that lesbigatr-questioning youth need "treatment" rather than civil rights.

In contrast, the majority of adults diagnosed with GID are self-identified transsexuals who usually must receive the diagnosis in order to get hormones, surgeries, and in some cases reimbursement for transition-related care. GID has also been used to gain legal protections for transgendered people in some jurisdictions, under the aegis of laws prohibiting discrimination against people with psychiatric disabilities. Because we understand these realities, WE DO NOT ADVOCATE an immediate, blanket elimination of GID in a vacuum, without an alternative means of ensuring continued access to and reimbursement for hormones and surgeries.

We believe that the best long-term solution to this dilemma is to eliminate GID as a psychiatric disorder and to redefine transsexualism as a medical condition. The existing system of access to transition-related health care is grossly inadequate and unfair. It vests psychiatrists with far too much power over access to hormones and surgeries. It denies our right to autonomy and self-definition. And it excludes the vast majority of transsexual people from any hope of reimbursement for

transition-related care. We believe that shifting the definition of transsexualism from a psychiatric to a medical status will help to alleviate these problems. We also recognize that achieving this goal will be a difficult task. As a first step, it is essential for transgendered people to demand more accountability from the psychiatric professionals who wield so much power over our lives.

We also believe that transgendered people need and deserve explicit civil rights protections. For a number of reasons, we do not believe that the disability rights model is either the only or the most effective way to achieve this goal. First, GID is explicitly excluded from protection in the Americans with Disabilities Act (ADA) and in the Federal Rehabilitation Act, as well as from most state disability laws. Second, legal protections based on GID as a psychiatric disability have some serious drawbacks, not the least of which is perpetuation of the stereotype that transgendered people are inherently unstable or disturbed. Accepting the idea that we are mentally ill in order to gain protection on the basis of disability will not, for example, protect transgendered parents who are denied custody or the right to adopt because courts believe that a parent with GID is harmful or "confusing" to children. Nor will it necessarily provide transgendered people with comprehensive protection against job discrimination. Even under the ADA and similar laws, the extent to which employers must accommodate people with mental illnesses is highly contested and unclear.

Third, the disability model invests mental health professionals with too much arbitrary and unchecked power over our lives. In the prisons, for example, this drawback has already had very negative consequences. While some transsexual inmates have won legal cases holding that transsexuals have a right to treatment based on a diagnosis of GID, courts have consistently deferred to the professional judgment of prison psychiatrists and held that psychotherapy, tranquilizers, and even forced testosterone "therapy" for self-identified female transsexuals are sufficient to satisfy this legal right. Under the psychiatric disability model, the ultimate authority to define our identities will always belong to psychiatrists, not to us.

Finally, the strongest argument against exclusive reliance on a disability model is the growing number of jurisdictions that prohibit discrimination against transgendered people without reference to GID. These include Minnesota, San Francisco (CA), Santa Cruz (CA), Seattle (WA), Cedar Rapids (IO), Minneapolis (MN), and St. Paul(MN). At the international level, the European Court of Justice recently held that employment discrimination against transsexual people violates the fundamental human right to be free of discrimination based on sex. We believe these victories are the beginning of a new era in transgendered civil rights, and solid evidence that we have the potential to move beyond the disability model to a more comprehensive civil rights movement.

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GENDER IDENTITY DISORDER IN CHILDREN

AN INFORMATION SHEET

(compiled by Shannon Minter; 11/96)

WHAT IS "GENDER IDENTITY DISORDER"?

Gender Identity Disorder (GID) is a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Psychiatric Association's official nomenclature of disorders. As defined in DSM-IV (1994), GID embraces a broad spectrum of people. Those diagnosed with GID range from adults to children as young as two years old. ("For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years . . . " DSM-IV, p. 536). DSM-IV defines "gender identity disturbance" as a continuum, with transsexualism perceived to be at the most extreme or "disturbed" end of the spectrum, and deviation from social norms and expectations about gender at the other. Although DSM-IV includes a disclaimer that GID in children "can be distinguished from simple nonconformity to stereotypical sex role behavior by the extent and pervasiveness of the cross-gender wishes, interests, and activities" (p. 536), the diagnostic criteria focus almost exclusively on non-conformity to stereotypical behavior. The criteria for GID in children have become progressively broader with each new edition of the DSM. As of DSM-IV, for example, the diagnostic criteria no longer require that cross-gender behavior be accompanied by the "stated desire to be, or insistence that he or she is, the other sex," DSM-IV, at 537. Compare DSM-III, p.73 (1987).

The American Psychiatric Association eliminated homosexuality as a mental illness in 1973. (For an account of the political battles around this decision, see Ronald Bayer, Homosexuality and American Psychiatry: The Politics of Diagnosis (1981)). Published in 1980, DSM-III was the first edition of the DSM that did not list homosexuality as a mental illness. DSM-III was also the first edition to include the "new" diagnosis of Gender Identity Disorder. Gay studies theorist Eve Sedgewick has argued that GID in children provided a new conceptual framework for pathologizing homosexuality. ("How to Bring Your Kids Up Gay," Social Text, Vol. 29, p.18 (1990)). Lawrence Mass has also suggested that "American psychiatry is . . . engaged in a long, subtle process of reconceptualizing homosexuality as a mental illness with another name--the 'gender identity disorder of childhood'." (Dialogues of the Sexual Revolution, vol. 1, p. 214 (1990)).

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DIFFERENCES BETWEEN CHILDREN AND ADULTS

Children and adults have different legal and practical relationships to the diagnosis of GID. As minors, children are under the legal power of parents or other adults. As a result, children diagnosed with GID have little or no control over either the content or the objectives of their treatment. Treatment of GID in children is typically designed to eliminate the child's cross-gender behavior and/or identification, with the longterm goal of preventing adulthood transsexualism or homosexuality. There is no dispute among therapists that the overwhelming majority of children who are diagnosed with GID grow up to be lesbian, gay, or bisexual, while a small percentage grow up to be transsexual.

In contrast, the vast majority of adults diagnosed with GID are self-identified transsexuals who seek out and must obtain a diagnosis of GID in order to get access to hormones and/or sex reassignment surgery. As the trans community has gained more political power and visibility in recent years, there is a growing movement to challenge psychiatry's gatekeeping power over access to hormones and surgery by redefining transsexualism as a medical rather than a psychiatric condition, and to advocate for explicit civil rights protections for transsexual & transgendered people. (Such protections exist, for example, in Minnesota and San Francisco). This position has elicited vehement criticism from other transsexual activists who believe that criticizing GID will endanger access to hormones and surgery and undermine the argument that transsexuals should be included in laws that prohibit discrimination against people with psychiatric disabilities. (Federal laws prohibiting discrimination on the basis of disability explicitly exclude gender identity disorder from protection, and most -- but not all -- states have done so as well, either explicitly or through judicial interpretation of state disability laws. Oregon is a recent exception.).

THE DIAGNOSTIC CRITERIA FOR GID IN CHILDREN

GID in Boys

According to DSM-IV, boys with GID have a "marked preoccupation with traditionally feminine activities," including:

- "dressing in girls' or womens' clothes,"
- "drawing pictures of beautiful girls and princesses,"
- playing with "[s]tereotypical female-type dolls, such as Barbie,"
- preferring girls as playmates,
- assuming a "mother role" when playing house,

- avoiding "rough-and-tumble play and competitive sports,"
- and showing "little interest in cars and trucks."

GID in Girls

DSM-IV states that GID in girls is manifested by:

- "intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire,"
- preference for "boy's clothing and short hair,"
- identification with "powerful male figures, such as Batman or Superman,"
- preference for boys as playmates, "with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games,"
- a lack of interest in "dolls or any form of feminine dress up or role-play activity."

(For complete description of diagnostic criteria, see DSM-IV, pp. 532-38).

EXCERPTS FROM CLINICAL PUBLICATIONS ON THE DIAGNOSIS AND TREATMENT OF GENDER IDENTITY DISORDER IN CHILDREN AND ADOLESCENTS

Children Referred for Diagnosis and Treatment

The following excerpts from clinical reports describe children referred for diagnosis and treatment for GID:

> Toni, a 6-year-old girl with an IQ of 123, was . . . referred because of increasing parental concern over her gender identity development . . . . [ ] At the time of assessment, Toni had an 'ambiguous' physical appearance, with hair and clothing styles that would make it difficult for a stranger to tell her sex . . . . [ ] Toni was very interested in team sports, but she would play these only with boys and using boys' equipment. She also enjoyed playing with educational and other non-sex-typed toys, such as board games. Toni often requested stereotypic masculine toys as presents, but she also showed a mild interest in dolls, such as Barbie . . . . [ ] At times, she displayed exaggerated masculine motoric movements and would lower her voice. She was adamantly opposed to wearing stereotypically feminine clothes and dressed almost exclusively in pants. Her only concession was wearing a dress to church. she stated that she dressed 'like a gentleman' during the week but for church she dressed 'like a lady'. [ ] Toni was quite

> outspoken in her desire to be a boy. At school, she began to call herself a boy and to spell her name as 'Tony', which greatly alarmed her teacher.

Kenneth Zucker, "Gender Identity Disorders in Children: Clinical Descriptions and Natural History," in Clinical Management of Gender Identity Disorders, ed. Betty Steiner, (1985).

> Kevin [aged 10 years and 7 months] was referred for treatment of severe gender identity confusion following an independent evaluation at a local child guidance clinic. [ ] Kevin stated that he preferred to play with girls and with toys usually given to female children, such as dolls. Kevin's favorite television show was "The Bionic Woman," and his favorite game consisted of playing with a camper and a family of dolls. (In this game, Kevin fantasized that he was the mother). When asked if he would rather be a boy or a girl, Kevin vacillated between the two responses, feeling that it might be fun to be a girl but concluding that he would rather be a boy. Kevin also stated that in school other children called him names such as "sissy" and "fag" and that he was afraid to respond for fear of getting physically hurt. During this interview, Kevin's voice inflection and mannerisms were judged to be an exaggeration of feminine sex-type behaviors.

William Hay et al., "Treatment of Stereotypic Cross-Gender Motor Behavior Using Covert Modeling in a Boy With Gender Identity Confusion," Journal of Consulting and Clinical Psychology, 49(3):388, 389 (1981).

> Becky was referred for treatment at the age of 7 years 11 months by a psychiatric nurse specialist at the request of her mother. [ ] Throughout her childhood history, Becky dressed exclusively in boys' pants and often wore cowboy boots, while consistently rejecting feminine clothing (e.g., dresses) and jewelry. Her only use of feminine cosmetic articles was to draw a moustache and/or a beard on her face. She appeared masculine in her gestures, mannerisms, and walk.

George Rekers and Shasta Mead, "Early Intervention for Female Sexual Identity Disturbance: Self-Monitoring of Play Behavior," Journal of Abnormal Child Psychology, 7(4): 405, 407 (1979).

Relationship to Adult Homosexuality And/Or Transsexualism

"Green's prospective study of extremely feminine boys found that 75% to 80% were either bisexual or homosexual at the time of their follow-up in adolescence or young adulthood. Other follow-up studies by Money and Russo, Zuger, and Davenport have also yielded high rates of homosexuality -- 100% in the series reported by Money! Transsexualism, or at least intense gender dysphoria, has occurred at a rate much lower than would be

predicted from retrospective studies, but at a rate higher than would be expected based on general population prevalence rates." (Bradley and Zucker 1990).

"[T]he psychosexual outcome in males is predominantly atypical. Of 94 cases, 5 are transsexual (5.3%), 43 are homosexual or bisexual (45.7%), 1 is a heterosexual transvestite (1.1%), 21 are heterosexual (22.3%), and 24 are uncertain (25.5%). If the uncertain cases are excluded, then 70% of the cases are either transsexual, homosexual or bisexual, or transvestite, and 30% are heterosexual." (Zucker 1985).

"[C]hildhood cross-gender behavior is the age-specific presentation of a homosexual male or female." (Green 1995).

"[E]arly effeminate behavior is not merely a forerunner of homosexuality in that it forecasts homosexuality, . . . it is in fact the earliest stage of homosexuality itself." (Zuger 1988).

"The gender-disturbed child moving into adolescence is a sensitive individual with reduced anxiety tolerance, a rather weak sense of himself or herself, and a degree of gender insecurity. These factors may make it very difficult for this individual to contemplate heterosexual involvement . . . . The choice of a same sex partner may reduce that anxiety and may also coincide with that individual's need to reinforce his or her self-value through identification with another biologically similar but stronger individual . . . . Once begun, . . . sexual activity in itself is reinforcing because of the pleasure involved and the self-validation, both from other partners and from a group. This produces . . . a homosexual identity." (Bradley 1985).

"If the psychopathology of 'Gender Identity Disorder of Childhood' is one of the major etiological precursors to adulthood homosexual orientation disturbance (as the research indicates at present), it would now appear logical that homosexuality per se be re-examined as a mental disorder." (Rekers 1988).

Estimated Incidence of GID in Children

"The incidence of gender identity disorders is not known. A rough estimate can be made from studies linking childhood cross-gender behavior and adulthood homosexuality. Rates of predominant homosexuality appear to be 2% to 5% for males and 1% to 3% for females (Diamond 1993). Three-fourths of the gender identity disorder children from my prospective study . . . emerged as homosexual or bisexual. Thus, the incidence of gender identity disorder could be 1.5% to just over 3% for males and about half that for females." (Green 1995).

"Conservative estimates of prevalence might be inferred from data regarding the prevalence of transsexualism . . . . The prevalence rate . . . might also be derived from data regarding the prevalence of homosexuality . . . . Despite these problems, one could argue that GIDC, or its subclinical variants, may occur in two percent to five percent of children in the general population." (Bradley and Zucker 1990).

Motivation of Parents Seeking Treatment for GID in Children

"The principal long-range concern by parents with cross-gender children is later homosexuality or transsexuality. The public has long identified what was only demonstrated in Green's (1987) prospective research recently -- the association between childhood gender nonconformity and adulthood homosexuality." (Green 1995).

"Do parents have the right to request or demand treatment for gender identity disorder children? Under the United States legal system, parents have considerable latitude in raising their children. The U.S. Supreme Court held that Amish parents had the right to withdraw their children from mainstream American schools and continue their education in a traditionally ethnoreligious manner that could preclude their integration into the larger society. (Wisconsin v. Yoder 1972). In this age of human immunodeficiency virus-related diseases, parents have the right to refuse to have their children receive condoms in school (In re matter of Alfonso v. Fernandez 1993). Parents can decide to have or not have their children take formal religious training. Thus, parents have the legal right to seek treatment to modify their child's cross-gender behavior to standard boy and girl behavior even if their only motivation is to prevent homosexuality." (Green 1995).

"Not surprisingly, . . . the development of a heterosexual orientation is probably preferred by most parents of children with GIDC." (Bradley and Zucker 1990).

"Suppose that boys who play with dolls rather than trucks, who role-play as mother rather than as father, and who play only with girls tend disproportionately to evolve as homosexual men. Suppose that parents know this, or suspect this. The rights of parents to oversee the development of children is a long-established principle. Who is to dictate that parents may not try to raise their children in a manner that maximizes the possibility of a heterosexual outcome?" (Richard Green, 1987).

Rationales for Treating GID in Children and Youth

"Two short term goals have been discussed in the literature: the reduction or elimination of social ostracism and conflict and the alleviation of underlying or associated psychopathology. Longer term goals have focused on the prevention of transsexualism

and/or homosexuality." (Bradley and Zucker 1990).

"It is not presently possible to differentiate the pretranssexual from the pretransvestite or prehomosexual child, but nevertheless there are clinical rationales offered for the prevention of all 3 of these conditions." (Rekers 1988).

"There are . . . various rationales for intervening in the gender identity development of highly feminine boys or masculine girls. Some of these rationales rest on firmer empirical or medical-ethical grounds than others. At least two goals -- elimination of peer ostracism in childhood and prevention of transsexualism in adulthood -- are so obviously clinically valid and consistent with the medical ethics of our time that either, by itself, would constitute sufficient justification for therapeutic intervention." (Zucker 1990).

"I have not been impressed by the pervasiveness of peer ostracism during early childhood, though by late childhood its presence is more obvious. Thus, unless one wishes to advocate treatment in order to avoid subsequent peer ostracism, I am not convinced that this rationale is a compelling one. Moreover, to advocate treatment simply because others do not 'like' one's behavior can only be taken so far as a general principle. [] In my view, offering treatment to a child (either on his or her own or through parental consent) can be justified for a relatively simple reason. Cross-gender identification constitutes a potentially problematic developmental condition. Taken to its extreme, the outcome appears to be transsexualism." (Zucker 1985).

"A young person's natural instinct might be to just eat salty or sugary food. But every parent knows that's bad for them. They'll have a healthier life if they have a balanced diet. And emotionally they'll have an easier life if they're heterosexual." (Rothenberg 1995).

"A rationale for treating this gender dysphoria component in children is its relationship to later life distress. Not only is the continuing of a cross-gender identity problematic when expressed as transsexualism (now called gender identity disorder of adulthood), but for male homosexuals, elevated levels of depressions and anxiety are correlated with persistence of gender dysphoria (Wienrich et al., in press). (Green 1995).

"[A]t least for many 'homosexual' adolescents, object choice may be less fixed than is sometimes believed. [] For many adolescents and their families, the key issue is whether one can or should change what appears to be a developing homosexual orientation . . . . efforts to promote heterosexual functioning should focus on those individuals who have not yet had extensive homosexual experiences." (Bradley 1985).

Methods of Treatment

"Several therapeutic strategies have been employed to treat children with GIDC, including behavior therapy, psychotherapy, family therapy, parental counseling, group therapy, and eclectic combinations of these approaches." (Bradley and Zucker 1990).

"Although parents' verbal and physical prohibition of cross-gender behavior will not terminate it in the G.I.D. child, their disapproval of it -- in behavior and words -- needs to be consistent." (Sugar 1995).

"With the advent of television talk shows, . . . male and female transsexuals parade regularly before the television cameras to be witnessed by children at home after school. Formerly, I would tell gender-disgruntled youngsters that they could not change gender, so they might as well find the best of being the gender to which they were born. Now, children know that they 'can get an operation'. I tell them, however, that children cannot get the operation, and that when adults do they do not really change sex, and further that they cannot have any of their own children after the operation." (Green 1995).

"My position with him tonight in play was that I can understand that not everybody likes to play ball, ... but at the same time he doesn't have to do girlish things. That's something, doing sissy things, that people make fun of . . . . he's going to be very unhappy doing sissy things. He heard me. He just sat there. He was playing with a doll while I was saying it. He got a little upset and put the doll away . . . . I told him that as he grows up, and if he continues to do sissy things, that he won't have many friends, and people will make fun of him, and that he'll be very unhappy. (Green 1987).

"After a thorough behavioral assessment has documented a pattern of cross-gender behavior, professional ethics would require informing the child's parents or guardian regarding (a) the possibility of transsexualism, transvestism, or homosexual orientation, and (b) the behavioral treatment interventions that have been demonstrated to reverse these cross-gender behavior patterns." (Rekers 1988).

"The behavioral approach assumes that children learn sex-typed behaviors and that these behaviors can be shaped . . . by encouraging some and discouraging others. Therapy, accordingly, consists of systematically arranging that rewards follow sex-appropriate behaviors and that no rewards (or perhaps punishments) follow sex-inappropriate behaviors. The behavior targets of intervention have included a variety of cross-gender behaviors, including toy and dress-up play, role-playing, exclusive affiliation with the opposite sex, and mannerisms." (Zucker 1990).

"[I]ntervention with parents of gender-disturbed children should involve advice regarding discouragement of gender inappropriate

behaviors and encouragement of same-sex activities and peer involvement. . . . With the gender-disturbed early adolescent, efforts to diminish cross-sex mannerisms and social skill training to allow better integration with same-sex peers seems critical." (Bradley 1985).

"The therapist . . . met with Kevin weekly for 1-hour sessions throughout the 15 weeks of treatment. During each treatment session, the therapist described the covert modeling sequence in detail and waited for Kevin to acknowledge that a sequence was clear in his mind by raising his index finger . . . . An example of a treatment sequence was as follows: You are walking out of school onto the playground. You imagine that Steve Austin, the Six Million Dollar Man, is walking ahead of you. You look at how he walks and you want to walk just like him. You see that he takes long smooth steps and his hips don't swish or move from side to side as he walks. His arms hang loosely at his side. He doesn't move his hands very much when walking and his wrist isn't limp or loose." (Hay et al. 1977).

"Becky's mother explained to her that treatment would be undertaken because Becky 'acted too much like a boy' and because she didn't want her to 'be like a boy' when she grew up . . . . Becky was observed and treated in a clinic playroom . . . . The research assistant gave Becky a wrist counter and gave her these instructions: 'You may play with any of the toys that you like, but you can only press the wrist counter when playing with girls' toys.'" (Rekers and Mead 1979).

"When he was five, Kyle entered a behavior modification program . . . in a laboratory setting and at home. At home, a token reinforcement program was instituted. Kyle received blue tokens for "desirable" behaviors, such as play with boys' toys or with boys, and red ones for "undesirable" behaviors, such as doll-play, "feminine" gestures, or playing with girls. Blue tokens were redeemable for treats, such as ice cream. Red tokens resulted in a loss of blue tokens, periods of isolation, or spanking by father. The treatment program lasted ten months." (Green 1987).

"Since the patient had a dominant transsexual fantasy to which he frequently masturbated, it was felt that aversion therapy might be successfully used to alter this fantasy as well as his homosexual attractions. In repeated sessions the patient was asked to imagine his transsexual fantasy and, when he indicated a clear image, an electric shock was delivered to his forearm until he signaled that the fantasy had ceased." (Barlow et al. 1973).

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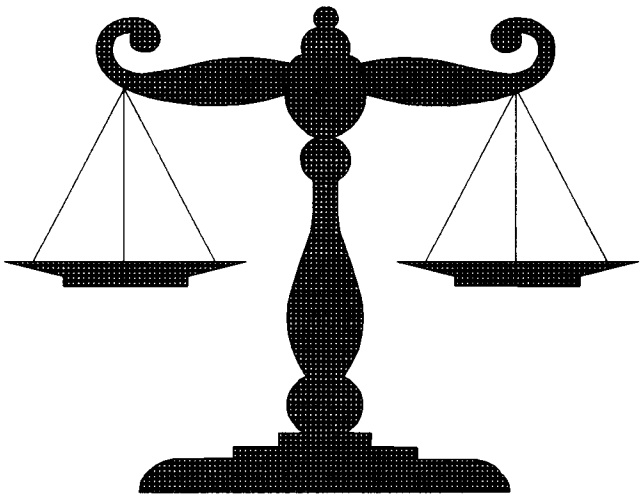

LESBIAN, GAY, BISEXUAL & TRANSGENDERED YOUTH

FACT SHEET ON ISOLATION, HARASSMENT & VIOLENCE

ISOLATION

In a 1991 study of lesbian, gay, and bisexual youth in the South, 97% reported openly homophobic attitudes by classmates. Only 2% found a peer group that was not hostile to lesbian and gay people.[1]

A recent national survey of male teenagers aged 15 to 19 found that only 12% would be friends with a gay peer.[2]

In a 1993 of 120 lesbian and gay high school students in Ohio, three-fourths reported negative reactions at school, including rude comments and jokes, harassment, and violence. Less than one student in five could identify a single person who had been supportive of them.[3]

In a 1988 study of 2,000 lesbian, gay, bisexual, and transgendered youth between the ages of 12 and 21 in New York City, over 95% reported that they frequently felt separated and emotionally isolated from their peers. Over 50% had been ridiculed because of their sexual orientation or gender atypicality.[4]

A 1983 study of lesbian and gay youth in New York City found that 70% of the youth surveyed identified isolation as their number one problem.[5]

In 1995, a national survey of high school health teachers found that less than half (43%) felt that the counseling staff in their school would be supportive of lesbian or gay students.[6]

VIOLENCE AND HARASSMENT IN SCHOOLS AND OTHER COMMUNITY SETTINGS

In 1993, a national survey of 3,000 female students between the ages of 9 and 15 found that students identified being called lesbian or gay as the worst form of verbal harassment, even compared to threats of physical assault.[7]

A 1987 study of 29 gay and bisexual male youths in Minnesota found that 30% had been the victims of physical assaults, half of which occurred on school property. Over 50% reported repeated verbal abuse from classmates.[8]

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A 1988 survey of New York State junior and senior high school students showed that nearly one third (31%) had witnessed acts of violence directed at students or teachers thought to be lesbian or gay.[9]

A 1995 study of lesbian and gay youth between 15 and 21 found that 80% had experienced verbal abuse. Of the gay male youth surveyed, nearly half (44%) had been physically threatened, nearly one third (30%) had been chased or followed, and 13% had been spat on. 17% had been physically assaulted (punched, kicked, or beaten); 10% had been assaulted with a weapon; and 22% reported sexual assault.[10]

A 1992 study of lesbians and gay men in Philadelphia found that 57% of the men and 30% of the women reported harassment or violence in junior high, senior high school, or college.[11]

A 1991 survey by the National Gay and Lesbian Task Force Policy Institute found that 37% of lesbians and gay men reported experiencing harassment, threats, or actual violence in junior and senior high school.[12]

In 1988, the Governor's Task Force on Bias-Related Violence in New York reported that teenagers surveyed about their biases against a variety of minorities reacted more negatively to gay people than to any other group. The report noted that teenagers' written comments about gays were often "openly vicious," and that "a number of students threatened violence against gays."[13]

REJECTION AND ABUSE IN FAMILIES

A 1995 study found that over one third of the lesbian, gay, and bisexual youth surveyed had been verbally insulted by a family member, and 10% were assaulted by a family member because of their sexual orientation.[14]

A 1990 study of 500 lesbian, gay, bisexual and transgendered youth in New York City found that 40% had been violently assaulted. More than half of those who had been assaulted reported that the attack came from within their own families.[15]

In 1994, a national study of 1,925 lesbians found that almost one out of four (24%) had been beaten or physically abused by a family member while growing up.[16]

A 1987 study of gay and bisexual male youth between the age of 15 and 19 in Minnesota found that 43% reported strong negative reactions from parents about their sexual orientation. More than half had been forced to leave home because of parental rejection.[17]

Nationally, youth service providers estimate that lesbian, gay, bisexual and transgendered "throwaways" account for 30 to 40% of all homeless youth.[18]

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