Homosexuality and parenthood

Michael B King, Pat Pattison

Concern about homosexuals as parents rests on three main planks. Firstly, homosexual parents might consciously or unconsciously provide inappropriate role models for sexual development—they might convince their children of the desirability of homosexuality or disturb them by overt expression of affection for each other. Secondly, and particularly in relation to homosexual men, they might have sexual relations with their children. Thirdly, the children might be stigmatised by others, particularly their peers, intolerant of their parents' sexuality. There is also an explicit assumption that homosexuality is undesirable and its development in the child is to be avoided.[1]

Decisions in the courts

In the English legal system the court's approach in proceedings such as wardship, custody or access, adoption and fostering, is based on the precept that a child's welfare is paramount. The feelings of either one or both parents may be disregarded if the parent's actions or attitudes are judged detrimental to the child's wellbeing. No case can be a precedent for another; each must be dealt with individually. If one or both parents is homosexual the court must decide whether this has a bearing on the child's welfare.[2]

We discuss seven cases which exemplify many of the issues. (Appeal cases, House of Lords, 1977:612.)

In Re:D a mother obtained a custody order of her 7 year old boy by consent on the basis that the father, who was homosexual, was to be given reasonable access. Some time later the mother and her second husband stopped the father having access to the boy and applied to adopt the child. The father, who lived in a sexual relationship with a 19 year old man, refused to consent to the adoption. At the first full hearing the judge held that the father's consent could be dispensed with and that his access to the child should cease, on the grounds that contact with an openly homosexual father would be damaging to the boy. On appeal, the Court of Appeal granted access to the father under the supervision of the boy's grandparents, but on further appeal to the House of Lords the court restored the original decision. Although it expressed concern about possible serious damage resulting to the child from access to his father, the court failed to specify the nature of that danger.

Where the danger is specified it is often in the vaguest of terms. In M *v* M, (unreported, 23 March 1983, Court of Appeal) in which a homosexual mother (on legal advice) had already abandoned her application for custody of her two children, the court was asked to decide whether her partner should meet the children. It was concluded that the homosexual influence was "extremely dangerous" to the children, who might be "imbued with some silly ideas" which could affect their standards and behaviour in adolescence.

In Eveson *v* Eveson (unreported, 27 November 1980, Court of Appeal) a mother living in a homosexual relationship with another woman applied for custody of her 6 year old boy. Although two welfare officers' reports supported the mother's application, the judge commented that "their way of life would not be right or natural" and that the son might be taunted at school. The Court of Appeal upheld the lower court's decision and gave interim custody to the father.

In the case of S *v* S, a homosexual mother sought custody of two children.[3] A medical expert called by the father gave evidence that the children might find their mother's relationship socially embarrassing and a source of considerable anxiety. Her application failed.

In the recent case of Re: C a woman initially gained custody of her 7 year old daughter after a hearing in which the judge stated that the mother's homosexual relationship was not a deciding factor.[4] On appeal the court reversed the decision on the grounds that the child should be placed in the conventional heterosexual household offered by the girl's father. When the case came before the High Court medical evidence called by the Official Solicitor on behalf of the child concluded that though the mother's lifestyle was not ideal for bringing up children, her homosexual relationship presented no obstacle to adequate parenting. Custody was returned to the mother.

Homosexual fathers have the greatest difficulty in obtaining custody of, or even access to, their children. They face both the question of their sexual orientation and the inclination of courts to award custody to the mother. In Re: G (unreported, 23 March 1980, Court of Appeal) a homosexual father was refused access to his two girls aged 5 and 7 years, a decision which was upheld in the Court of Appeal. The judgment asserted that homosexuality of itself was not a bar to the father gaining access, but there were other factors—including a delay in the father re-establishing access during a period when it had lapsed. In Re: B (unreported, 27 July 1990) a homosexual man applied for custody of his two boys aged 8 and 10 years. Although of English origin, the family had lived abroad for many years. Medical evidence presented to the court on behalf of the father took the view that homosexuality was no bar to him gaining custody and that any potential embarrassment for the children could be overcome by the support of an extended family. Although it could be argued that requiring children to settle in a new country might cause more disruption than them coping with the fact of their father's homosexuality, the judge indicated that he would give custody to the mother and the case was settled by consent.

The evidence

An anonymous postal survey of homosexual women in Britain showed that of 29 women who sought custody, care, and control of their children between 1976 and 1984, 13 lost or gave up care and control, nine obtained care and control with joint custody, and seven obtained sole custody of their child.[5] What is the evidence that justifies the courts' concern about the

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BMJ 1991;**303**:295-7

development of the children in homosexual households?

Our understanding of psychosexual development remains largely descriptive. Gender identity is the unique sense of being male or female. It is not necessarily the same as biological sex, and disjunction between the two occurs in transsexualism. Gender identity is completely acquired between the ages of 2 and 4[6,7] and may be a function of both prenatal and postnatal influences.[8] Gender role is the collection of traits and behaviours which indicates to self and others that one is male or female. It is the public expression of gender identity, it is not simply restricted to sexual arousal or response, and it varies with the cultural setting.[8] Gender role socialisation begins early and becomes a part of conscious awareness once gender identity is established. Sexual preference or orientation relates to the gender of the perferred sexual partner. The determinants of sexual orientation and the timing of its development remain poorly understood. Nor are they necessarily the same in each sex.[7]

Even within the Western model of the nuclear family the psychosexual development of children is understood differently by different theorists.

Psychoanalytic theories underscore many of our assumptions that children require models of each sex for normal development. Although not all psychoanalytic theories of the development of homosexuality have invoked failure to resolve the oedipal phase, the end result is said to be identification with the mother or exaggerated libidinal identification with the father.[9,10] Doctrines of development such as these remain untested and are probably untestable.

Social learning theories postulate that effective male and female models are necessary for the appropriate learning of gender role.[6] Observational learning, modelling, and various cognitive processes occur in a background of social reinforcement and conditioning.[11] Even parents who consciously avoid sexual stereotypes in interacting with their children can be shown to behave towards daughters differently than to sons on at least some criteria.[8]

Finally, endocrine factors, genes, and the development of central nervous structures have been variously invoked to explain gender identity, role, and orientation.[7] There have been interesting leads but little unequivocal evidence linking any particular biological factor with development of gender role or sexual orientation.[12]

Most children who develop a homosexual orientation have heterosexual parents. Indeed, if social learning hypotheses are credible it is a wonder that a homosexual orientation develops at all in the face of strong family and societal models for heterosexuality. In the largest controlled community study of its kind retrospective accounts by homosexuals of their parenting found no major differences from those of heterosexual people.[13] Overly "seductive" relationships with opposite sex parents or sexual experiences with same sex parents were not reported by more homosexual than heterosexual respondents.

Do parents who are homosexual have an effect on the psychosexual development of their children? Two studies have used standardised measures. The first compared 27 female homosexual households containing 37 children with 27 households where heterosexual women were solo parents to 38 children.[14] More than half the homosexual mothers were cohabiting in a stable relationship with another woman. Ratings of the children's psychiatric state, peer relationships, and sexual orientation were made by assessors blind to the type of family. In the second study, 50 female homosexual mothers and their 56 children were compared with 40 heterosexual single mothers and their 48 children.[15]

The two groups of children did not differ in terms of gender identity, sex role behaviour, sexual orientation, emotions, behaviour, and relationships. The children of these homosexual mothers did not seem to have been stigmatised, although other evidence suggests that some children may have a conflict between loyalty to their mother and a desire to conform to the heterosexual norms of their peers.[16] Evidence from uncontrolled studies supports the findings of these two studies.[17-19]

Homosexual fathers in sole custody of their children are uncommon because they seldom apply for—or are usually denied—custody by the courts. To our knowledge there have been no controlled studies of the type described for women. Findings so far, however, have failed to establish any unexpected trends in the psychosexual and emotional development of children raised in such households.[18,20-22]

No comparison has been made between homosexual and heterosexual couples where each has suffered marital break up and repartnering. Neither have children raised by homosexuals been followed up into adulthood. Finally, although homosexual women are increasingly seeking to have children through sexual intercourse or by artificial insemination,[23] to our knowledge the development of these children has not been studied long term.

Paedophilia occurs most often in men and may be heterosexual, homosexual, or gender blind with respect to the sex of the child. Classification of male offenders into those who are fixated on children and those whose adult sexual orientation changes to children under stress has not proven helpful.[24] Evidence has emerged that children of both sexes and adult women are often assaulted by the same man.[25] The traditional distinction between paedophilia and incest[26] has also been challenged by those who find little difference between them.[24] Despite popular confusion between (particularly male) homosexuality and paedophilia there is no evidence for any connection between the two. Children are at just as much risk of sexual assualt by a heterosexual parent or stepparent as by a homosexual counterpart.

We believe that the findings of our review have important implications for custody and access applications before the courts, adoption of children by homosexual parents of either sex, and women homosexuals conceiving and raising their own children. Professionals giving evidence to the courts need to be aware of their own emotional or moral biases. Courts frequently assume that the more "professional" the expert the sounder the evidence. We believe that this proposition is unsafe.

Lawyers nowadays deal with more cases in which a homosexual factor is present—but most do not proceed to full trial or are unreported. As was the case in Re: B in those that do reach the courts the judge will often intimate his views to both parties in the hope that they will settle the case before a formal judgment is made. Many lawyers are reluctant to advise homosexual clients to fight for custody of their child: they know that if there is a heterosexual family in which a child may be placed, the courts are unlikely to prefer the homosexual family as an alternative. We would assert that lawyers should persuade their homosexual clients to bring their cases before the courts. Only by challenging the status quo can further debate and research be stimulated.

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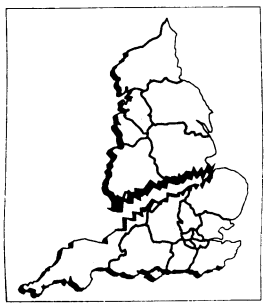
(Accepted 18 April 1991)

The Health of the Nation: responses



First steps towards a strategy for health

Richard Smith

We are clear about one thing: a strategy imposed by government which takes no heed of the views of those who will have to implement it, including the people themselves, is valueless.

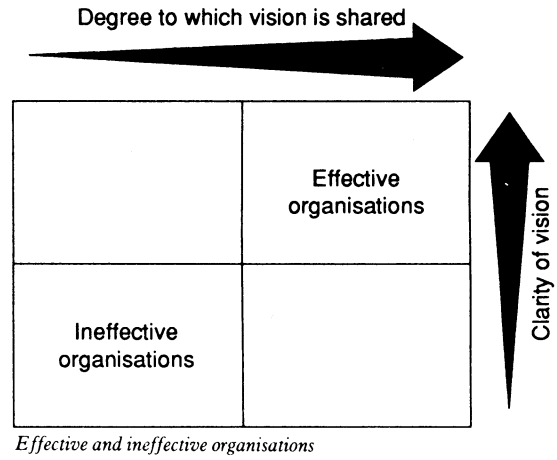
This quote from Mr William Waldegrave, Secretary of State for Health comes from his introduction to *The Health of the Nation*, the consultative document that sets out a strategy for improving the health of the English.[1] It's a pity that the strategy for the NHS didn't follow the same philosophy (and Mr Waldegrave has said so himself),[2] but it is true that the strategy for health will not work if the many individuals and organisations that will have to act to make it work do not feel any ownership. As John Harvey-Jones, the former chief executive officer of ICI, explains in his book *Making it Happen*, this does not have to mean that the strategy degenerates to the lowest common denominator that everyone can agree on: people and organisations will put their backs into making a strategy work as long as they are convinced that they have been heard—even if not all of their proposals have been accepted.[3] And they cannot all be. As Mr Waldegrave says elsewhere in his introduction: "priorities are meaningless if they include everything."

Taking Mr Waldegrave at his word on wanting to listen to everybody, we have commissioned a series of articles in response to *The Health of the Nation*. They address each of the 16 key areas identified in the strategy and other subjects that might qualify as key areas. For each key area we have asked authors to make the case that it should be a key area; consider the case against; identify what the targets should be within the key area; suggest a strategy for reaching the targets; and then identify barriers to reaching them. Not all of the papers will follow exactly this format. We are also publishing with this article a paper by Allyson Pollock from the Radical Statistics Health Group: she is strongly critical of the strategy (p 299).[4] Readers are invited to contribute to the debate through our correspondence columns, and this has already begun (20 July, p 148).[5,6] At the end we will attempt a summary. We plan to publish all of these articles before the end of October, when the government's consultation period ends.

Why a strategy?

Effective organisations know where they are going. "The secret of success," said Benjamin Disraeli, "is constancy to purpose." Organisations that drift—like much of British industry in the past—are prone to disappear. Organisations that have strategies can concentrate on what they do best and devote resources (which are always limited) accordingly. The strategy should motivate people and allow them to work hardest at the activities that will produce the richest return. Setting a strategy also forces people to look to the future, making it more likely that they will see emerging opportunities early and be able to exploit them and notice the spot on the horizon that is an express train coming to destroy them—giving a chance of getting out of the way.

The figure is a device for analysing the effectiveness of organisations. The more effective live in the top right hand corner and have a clear vision that is shared by most of those within the organisation: Toyota, IBM, Sainsbury's, the Vietcong, and Intenational Physicians for the Prevention of Nuclear War have been in this square. Most organisations exist in the least effective, bottom left hand corner—with little sense of collective vision. The NHS has probably been in the bottom right hand corner with a vision that has been shared but unclear. *The Health of the Nation* might push it to the effective top right hand corner, or



Effective and ineffective organisations

British Medical Journal, BMA House, London WC1H 9JR
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BMJ 1991;**303**:297-9