Non-heterosexuality: Contemporary Psychiatric Perspectives

Meng-Chuan Lai, M.D.1,2, Susan Shur-Fen Gau, M.D., Ph.D.1,3, Yen-Nan Chiu, M.D.1

Background: Although homosexuality has long been de-pathologized from psychiatric diagnoses since 1973, explicit and implicit discrimination toward non-heterosexuality still exists. Most biases are rooted deeply in the prevailing heterosexist value system, yet they are also highly strengthened by misunderstandings toward the diverse and multi-dimensional nature of human sexuality. In the past decades, mental health professionals, psychologists, social scientists, biologists and gender researchers from various disciplines have contributed greatly to the understanding toward non-heterosexuality. The accumulated knowledge is bound to improve our understanding toward human sexuality, and hopefully to reduce the long-standing biases and discriminations toward non-heterosexuality. Method: We reviewed current literature (mainly from Western studies) about non-heterosexuality from psychiatric perspectives. Results: First, we introduced the definition and conceptual framework for non-heterosexuality, along with brief summaries of demographics and biological underpinning. Second, we addressed psychological issues, including identity development, heterosexism and internalized homophobia, mental health and suicidality, and same-sex committed relationship. Third, we gave a brief overview toward psychotherapeutic issues on working with non-heterosexual individuals and their families. Conclusion: We suggest our Taiwanese mental health colleagues to achieve a better understanding toward non-heterosexuality, to do non-biased and non-harmful clinical practices based on affirmative stance, to distribute knowledge to all health care providers, and to promote legal equality for Taiwanese non-heterosexual people.

Key words: sexuality, homosexuality, non-heterosexuality, developmental psychology

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Introduction

Although psychiatry has long been criticized and stigmatized as a discipline medicalizing non-heterosexuality, contemporary psychiatry has adjusted its perspectives in past decades owing to the accumulated scientific evidences supporting the normality of the diverse nature of sexuality, and the social trends advocating individual liberation. Affirmative stance is regarded fundamental in psychotherapeutic works with these individuals [1]. Yet this is never simply a scientific issue. For example, the chapter on homosexuality had not been listed in the section “Normal Sexuality” of the classic Kaplan & Sadock’s Comprehensive Textbook of Psychiatry until 2000, despite that homosexuality no longer defined as a mental disorder by the American Psychiatric Association (APA) since 1973 [2, 3]. In this overview we intended to introduce current psychiatric perspectives and up-to-date knowledge.

Non-heterosexuality: Conceptual Framework and Demographics

Human sexuality is diverse and multi-dimensional in nature, and can be summarized in at least six parallel but mutually related dimensions [4], including biological sex, gender identity, gender role characteristics, sexual behaviors, sexual orientation, and sexual identity. Non-heterosexuality broadly refers to the sexual condition of people who are not exclusively heterosexual in their sexual orientation, behavior, identity or relationship. Many past literatures defined sexual orientation by three components: desire, behavior and identity [1]. We consider this definition likely to be semantically confusing, that a single term sexual orientation referring to three distinct constructs (sexual desire, sexual behavior, and sexual identity) of sexuality may cause conceptual mistiness about the actual meaning of the term sexual orientation and the sexual construct it signifies. Therefore, we advocate for Savin-Williams’s framework that non-heterosexuality, as well as heterosexuality, is viewed as the constitution of three distinct dimensions: sexual orientation (which is narrowly defined as describing inner erotic desire, feelings, thoughts, attractions and fantasies), sexual behavior, and sexual identity [5, 6]. The three dimensions can be correlated to each other, but are not mutually defined. Of the most important, sexual identity is not given or defined by others, but rather constructed, adopted and labeled by the person him/herself. Comparison of the three concepts is provided in Table 1 [5]. Terms in the text below follow these definitions.

Under this conceptualization of non-heterosexuality, recent Western surveys [7-10] revealed

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<tr>
<th>Table 1. Domains of sexual definition</th>
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<tr>
<td>Sexual orientation</td>
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<tr>
<td>A matter of choice</td>
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<td>Stable over time</td>
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<td>Awareness</td>
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<td>Uniquely adolescent</td>
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(Reprinted by permission of the publisher from THE NEW GAY TEENAGER by Ritch C. Savin-Williams, p. 29, Cambridge, Mass.: Harvard University Press, Copyright © 2005 by the President and Fellows of Harvard College.)
that in adults, prevalence rates were highest for same-sex orientation (7.5-14.0%), followed by same-sex sexual behaviors (1.3-13.0%) and gay, lesbian or bisexual identities (1.4-6.0%), with gender (higher rates for orientation in females and behaviors in males) and cross-cultural (higher in Western Europe than in the U.S.) differences. For current adolescents, Savin-Williams concluded [5] that at least 15-20% have some degree of same-sex orientation, and among them less than half are exclusively same-sex oriented. Comparing with the large numbers of teens with non-heterosexual orientation, only 3-4% among all embraced gay/lesbian/bisexual identity, and 3% reported same-sex sexual behaviors.

**Biological Underpinning**

Although certain neuroanatomic (e.g. the size of the human third interstitial nucleus of the anterior hypothalamus [11, 12]) and anthropometric (e.g. the second-fourth digit ratio, which is related to the level of prenatal testosterone exposure [13-15]) characters have been proposed to be associated with homosexual orientation, no conclusion has been made. Reasons may include phenotypic mistiness, particularly the conceptual mistiness of sexual orientation with gender role characteristics and other sexual dimorphic features in many previous studies.

Some stronger evidences have been reported to support a genetic component in sexual orientation [16-21]. Monzygotic vs. dizygotic twin concordance rates for self-identified homosexuality were 52% vs. 22% for males [16], and 48% vs. 16% for females [17], respectively. Estimated heritability for adult sexual orientation (same-sex sexual fantasy and attraction) from a large community-based Australian twin cohort (n=4,901) were 0.30-0.51 for males and 0.23-0.58 for females by different model fitting [18-20], meanwhile with comparable non-shared environmental effect. In a U.S. national sample of twin and non-twin sibling pairs (n=2,907), estimates of the heritability of liability of sexual orientation ranged from 0.28 to 0.65, the impact of common environment ranged from 0.00 to 0.39, and the impact of individual-specific environment ranged from 0.33 to 0.35 [21]. Despite the findings of significant heritability, gene-hunting studies have not yielded consistent results. This may be due to the complex phenotypic construct of non-heterosexuality (i.e., phenotypic heterogeneity), the complicated genetic composition (i.e., genetic heterogeneity), and the presence of gene-environment interplay [19].

**Four Fundamental Psychological Issues**

After de-pathologizing of homosexuality, psychologists and psychiatrists turn to investigate the development and adaptation of non-heterosexual individuals and to the promotion of their well-being. Four fundamental issues have received the most attention in past three decades.

**Identity development**

Research findings in 1970s to 1980s [22-28], revealed that most homosexual participants reported a linearly evolving process of identity development (Table 2). These linear developmental models were constructed mainly from the developmental experiences of white American gay men growing up in the mid-20th century, who experienced overwhelming heterosexism throughout their lives. These linear processes should be seen to reflect their struggle against prejudice, the resolving of negative self-image and the associated socialization. But due to the more liberal public attitudes toward non-heterosexuality nowadays,
some studies on American adolescents in the past two decades have depicted diverse developmental trajectories [5, 29-34]. Some still followed the linear paths, yet others developed through various routes (e.g. some identified themselves as gay before any same-sex behavior or romantic relationship [32], some changed sexual identity for several times in adulthood [31, 35], still others rejected any identity label while living a stable and happy life [5].) Gender differences in these trajectories of sexual identity milestones include being relatively emotionally oriented for women and sexually oriented for men, and that women usually follow label-first trajectories, whereas men are more likely to pursue sex before identifying themselves as gay [34]. Female sexual identity is thought to be more fluid and flexible [30, 31, 36].

Savin-Williams proposed the model of differential developmental trajectories (DDT) to describe these diverse, flexible and complex developmental paths for recent American non-heterosexual youths [5, 6]. Developmental milestones (feeling different, same-sex attraction, identity label, same-sex sexual behaviors, disclosure of same-sex sexuality/coming-out, romance relationship, acquisition of a positive identity, and disclosure to parents) are classified to describe individual trajectories, which varied one from another [6]. A qualitative study on Taiwanese lesbians [36] also supported the DDT model. Based on clinical experiences, we have found that it gives a better framework to understand the sexual identity developments in current Taiwanese non-heterosexual youths.

**Heterosexism and internalized homophobia**

To victimize non-heterosexual people is highly mentally detrimental. The term homophobia is originally described for the dread of the public on homosexuality, and the self-loathing of the non-heterosexuals. For conceptual clarity, recent literatures classified both of them as anti-homosexual prejudice, in which heterosexism described prejudice in the social context, and internalized homophobia the inner feelings of shame, guilt, disgust and hatred towards themselves of non-heterosexual people [37].

| Table 2. Models of gay and lesbian identity formation (linear developmental models) |
|---------------------------------|-----------------|-----------------|-----------------|
| Identity Confusion             | Sensitization   | Pre-Come Out     | Emergence       |
| Identity Comparison            | Identity Confusion | Coming Out       | Acknowledgement |
| Identity Tolerance             | Identity Assumption | Exploration     | Finding Community (men) |
|                                |                  |                  | First Relationships (women) |
| Identity Acceptance            | Commitment       | First Relationships | First Relationships (men) |
|                                |                  |                  | Finding Community (women) |
| Identity Pride                 | Commitment       | Integration      | Self-Definition and Reintegration |
| Identity Synthesis             |                  |                  |                  |

Heterosexism is defined as “a world-view, a value-system that prizes heterosexuality, assumes it as the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual” [38], and is classified into cultural heterosexism and psychological heterosexism [37]. The former operates through a dual process of invisibility and attack, whereas the latter presents by verbal and behavioral abuse, discrimination and assault in an individual level. Both mechanisms lead to internalizing negative self-image, and derogating self-esteem and self-concept, are likely to cause internalized homophobia and the associated psychiatric symptoms.

Heterosexism and internalized homophobia can cause social withdrawal and passivity, obsessive anxiety, suspicion and insecurity, chronic hypervigilance, maladaptive behaviors, self-loathing and depression, over-idealization of heterosexism, avoidance of intimate relationships or sexual lives, and over-compensation in other aspects of life (e.g. academic performance) [22]. The harmful developmental consequences for the self include large amounts of time and energy being devoted to survival and defense rather than to intimacy and growth, a generalized view of the world as threatening and dangerous being developed, two selves (public self and private self) being created, and a sense of shame about core identity and basic needs being fostered by isolation [28]. Therefore, public education to reduce the societal negative stereotypes and heterosexist prejudices is needed.

**Mental health and suicidality**

The figures of gay youth in psychiatric and public health literatures from 1980s to 1990s were mainly “troubled and suicidal” [39, 40]. These findings were strongly challenged for their poor external validity. In the past decade, epidemiological studies on Western large-sized representative samples have suggested that sexual orientation, behavior and identity, as well as biological sex, age and ethnicity, were demographic correlates for suicidality and mental health problems. To give a general impression, latest results from meta-analyses revealed at least 1.5 to 2 fold risks for suicide attempts, depression and anxiety disorder, and alcohol and other substance dependence in lesbian, gay and bisexual people [41]. But the numbers vary by the different aspect of studies.

In adolescents, earlier studies on U.S. regional samples showed that compared with gender-matched heterosexuals, self-identified homosexual/bisexual males had 3.6 and 7.1 times higher risks for suicidal intents and attempts, respectively [42]. But gay, lesbian and bisexual (GLB) adolescents were more likely to be victimized and threatened, and to be engaged in multiple risk behaviors [42, 43]. Non-heterosexual identity had an independent association with suicide attempts for males, while for females the association was mediated by drug use and violence/victimization behaviors [44]. A recent Norwegian longitudinal study (n=2,924) revealed that considering homosexual attraction, homosexual identity, and same-sex sexual behavior together to predict suicidal attempt, only same-sex sexual behavior was significantly predictive [45]. The U.S. National Longitudinal Study of Adolescent Health (n=11,940) showed that adolescents (aged 13-18 years) with same-sex romantic attraction or relationships were more likely to have suicidal thoughts (OR = 1.68 for males, 2.14 for females) and attempts (OR = 2.45 for males, 2.48 for females) in the preceding year [10]. This relationship was significantly mediated by critical youth suicide risk factors including depression, hopelessness, alcohol abuse, recent suicide attempt by a peer or a family member, and experiences of victimization [10]. A follow-up study of the same co-
hort confirmed that self-identified homosexual and bisexual young adults (aged 18-26 years) had 2.9 and 3.0 times higher risks of suicidal ideation and suicidal attempts within the preceding year, respectively, than their heterosexual counterparts [46].

Similar results were evident for adults. By behavioral aspect, findings from American twin sample [47], New Zealand birth cohort [48] and Dutch population-based survey [49] showed that adults with same-sex sexual partners had higher suicidality (up to 4-6 times) and risks for mood and anxiety disorders (up to 3-4 times), substance misuse (up to 4-5 times), and conduct disorder (3.8 times) than their counterparts. Among sexually active U.S. college students, those with bisexual activities (particularly females) were more likely to have used illicit drugs than those with exclusive same- or opposite-sex partners [50].

Regarding identity aspect, Australian self-identified bisexuals rated highest on measures of anxiety, depression and suicidality among all, and homosexuals ranked the second [51]. Considering orientation aspect, New Zealand adults with same-sex attractions had higher risks of self-harm (up to 2-5 times) and substance misuse (3 times) [52], and Dutch adults with same-sex or bisexual sexual preferences reported more acute mental and physical symptoms than the heterosexuals [53]. In Taiwan, a recent report investigating mental health of college students showed that 12.9% of homosexuals and 4.8% of heterosexuals were severely depressed, and 2.4% of homosexuals and 0.8% of heterosexuals had recent suicidal attempts [54], indicating to have comparable high risks as those in the Western counterparts.

In summary, non-heterosexual people suffer from a higher risk for mental health problems and suicidality than their heterosexual counterparts. Societal oppression, prejudice and rejection, and the victimization and discrimination that non-heterosexual individuals exposed were considered critical underlying mechanisms, and were empirically proved relevant [55-57]. In general, the minority stress model, a framework for the unique stressors and their effects on well-being for sexual minorities, is considered the most applicable model elucidating the complex relationship between non-heterosexuality and mental health [58]. Contrariwise, we should acknowledge that many non-heterosexual people are resilient and free from mental illness and suicidality [5]. Non-biased approaches should be implemented in research and during clinical encounters with non-heterosexual individuals, just as with the heterosexuals.

**Same-sex committed relationships**

**Similarities and differences from heterosexual couples**

As opposed to social stereotypes, Kurdek concluded from research that “despite external differences in how gay, lesbian and heterosexual couples are constituted, the relationships of gay and lesbian partners appear to work in much the same way as the relationships of heterosexual partners.” [59] Same-sex couples closely resemble their opposite-sex counterparts in their psychological and social dynamics, that they also form deep emotional attachments and commitments, face similar challenges in love, intimacy, loyalty, equity and stability, express comparable satisfaction with their committed relationships, and share similar socio-psychological processes predicting relationship quality with their heterosexual counterparts [60-62]. Many non-heterosexual persons want to form long-lasting committed relationships [63], which are actually common [60].
Yet some differences do exist: (A) Cohabiting same-sex couples are less likely to divide household labor by culturally defined gender roles, and tend to share tasks more equally [61, 64, 65]. (B) Same-sex couples generally get less support from relatives but mainly from friends [60]. (C) The gender of the couple may influence their sexual practices: lowest frequency of sexual activity is reported by lesbian couples, and more gay male couples may discuss, accept or practice open sexual relationships [66]. (D) Lesbians and gay men are more likely to remain friends with ex-partners than heterosexuals [67]. In Taiwan, a survey on hundreds of partners showed that comparing to married and unmarried heterosexual couples and gay couples, lesbian couples valued most on the significance of self-disclosure, mutual trust, and love between the partners, and that they also showed the highest satisfaction on present couple relationships [68].

**Legal recognition of same-sex committed relationships**

Various legal statuses validating same-sex committed relationships (e.g. domestic partnership, civil union, or civil marriage) is one of the most essential and realistic protections of basic human rights for non-heterosexual people, and are recognized in most European and South American countries, New Zealand, Australia, and a few states in the U.S. Until 2009, same-sex civil marriage is officially recognized in The Netherlands, Belgium, Spain, Canada, South Africa, Norway, Sweden, and five states (California, Connecticut, Iowa, Massachusetts, and Vermont) in the U.S. [69] But proponents and opponents of marriage equality are still battling. From mental health perspectives, the well-being in various life dimensions (e.g. financial, legal, medical, social and psychological) of non-heterosexual people and their children will be substantially protected and enhanced under the rights, benefits and protections provided by civil marriage [70, 71]. For the interest of maintaining and promoting mental health, the APA holds a supportive stance on the legal recognition of same-sex civil marriage and all associated legal rights, benefits, and responsibilities, and opposes restrictions to those same rights, benefits, and responsibilities [72, 73]. Although Taiwan is already one of the most GLB-friendly countries in Asia, the legal recognition of same-sex committed relationships is still a long way to go. Mental health professionals could contribute more on this important issue to strengthen and to empower the same-sex couples and their families.

**Gay and lesbian parents**

Public (heterosexist) stereotype often questions the competency of lesbian mothers and gay fathers, and worries about the psychological and social well-being of children raised by same-sex couples. Researches in the past two decades have responded to these disputes.

First, gay fathers are not different from heterosexual fathers on the nurturance and investment in their parental role [74]. They are as fit and able as heterosexual men to fulfill parental roles [75]. Similarly, lesbian mothers show comparable self-esteem, psychological adjustment and child-rearing attitudes to their heterosexual counterparts [76-78].

Second, extensive research into preadolescent children raised by same-sex parents showed their comparable developments in gender identity, gender role behaviors and sexual orientation as those raised in heterosexual families [76, 79, 80]. Comparing with adults with divorced heterosexual parents, no differences were found in gender identity, gender role behaviors and sexual orienta-
tion of adults who had a divorced gay or lesbian parent (or parents) [81, 82]. Compared with those from heterosexual families, young adults grew up in lesbian-led families showed similar ratio reporting same-sex attraction, yet were more likely to consider the possibility of having a same-sex relationship [83-85].

Third, emotional development, social adjustment and mental health status are similar in children raised by same or opposite sex parents [82, 86]. They were more tolerant of diversity and nurturing toward younger children [86]. The latest study on a large probability sample found no significant differences in psychological well-being or family and relationship processes between adolescents parented by same-sex and opposite-sex couples [87]. In the aspects of possible stigmatization and peer rejection, these American adolescents were found to function well, and that the peer relations were not associated with their family type [88]. In the literatures from Taiwan, we found only two recent master’s theses which described lesbian couples' construction of families [89] and parenting practices [90].

To conclude, “there is no systemic difference between gay and nongay parents in emotional health, parenting skills, and attitudes toward parenting.” and “no data have pointed to any risk to children as a result of growing up in a family with one or more gay parents [79].” Children raised by same-sex parents are as healthy and well-functioning as those raised by opposite-sex parents [71, 79, 82, 87, 88, 91]. The APA supports child adoption and co-parenting by same-sex couples, and advocates that optimal development for children is not based on parental sexual orientation but on stable attachments to committed and nurturing adults [92].

The Helping Psychiatrists: Psychotherapeutic Issues

Individual works based on affirmative stance

Affirmative stance (i.e., acceptance, acknowledgment, and affirmation of non-heterosexual individuals) is essential [1], and the principle of nonmaleficence (do no harm) is fundamental to medical care. Non-affirmative practices convey harmful explicit or implicit discriminative bias (e.g. non-heterosexuality is pathological or abnormal), thus violate the code of medical ethics.

Affirmative psychotherapy describes a basic “tone” for psychotherapeutic works. It does not formulate a systemic approach or ground on a well-elaborated theory of human mind, yet does hold certain central ideas: non-heterosexuality is natural, healthy and normal (rather than deviate or pathological), and the core issue in therapy is internalized homophobia and heterosexism (rather than non-heterosexuality per se.) Most psychotherapeutic theories, models and techniques can be affirmative if the “tone” has been adjusted [93-95]. Here we summarize major issues for affirmative psychotherapeutic practices suggested by literatures [22, 94, 96-99] and our clinical experiences (Table 3). We also advocate resilience-based intervention for non-heterosexual youths to facilitate them to recognize and to mobilize their ordinary adaptation capability, and to help establish and maintain a supportive community and peer system.

Family and couple works

A major reason for psychiatric consultation is the issue of disclosing non-heterosexuality. Regarding coming-out, the first things to be discussed with the individuals are the timings, prepa-
rations, plans and measures, predictions of the consequences, and ways to avoid reckless disclosure, rejection of communication and conflicts with families afterwards. Equally important are the implicit and explicit influences from heterosexism and internalized homophobia on the decision-making of whether to come-out, and even on whether to talk about coming-out in sessions. Adequate preparatory communication before actual disclosure helps reduce the possible harmful consequences from a sudden or unmanaged disclosure [100]. Indigenous guidebook for non-het-

| Table 3. Suggested guidelines for affirmative psychotherapeutic practices |

- To make the client feel comfortable and secure.  
  - To understand and to recognize the diversity of non-heterosexuality. *(First do no harm by stereotyping!)*  
  - To create a friendly and supportive physical environment, and to help non-heterosexual clients feel visible and accepted.  
  - To use inclusive language, to mirror the client’s language concerning self-label and relationships, and to match with the client’s identity developmental condition.  
  - To develop a comfortable and appreciative orientation to the therapist’s own homosexual feeling, that the therapist’s own internalized homophobia should be carefully monitored and dealt with.  
  - To bring the subjective reality of the client’s experience of oppression into consciousness.  
  - To be very careful about the client’s request of changing sexual orientation.  
  - To help client identify, deprogram and undo the negative conditioning associated with the stereotypes.  
  - To be alert to facilitate the identification and expression of anger, shame, and guilt, for them to be constructively channeled.  
  - To actively support the client’s appreciation of the body-self and body impulses.  
  - To encourage the client to establish a gay/lesbian/bisexual support system.  
  - To work toward a collaborative relationship with the client. The key message is, “you are not a second class or inferior person.”  
  - To encourage the client to question basic assumptions about being non-heterosexual and to develop a personally relevant value system as a basis for self-assessment.  
  - To desensitize shame and guilt surrounding homosexual thoughts, feelings, and behaviors.  
  - To use the weight of professional authority to affirm non-heterosexual thoughts, behaviors, and feelings when reported by the client.  
  - To discuss about the pros and cons of passing strategies, and the plans of actual practices of such strategies.  
  - To discuss about issues of intimacy and generativity, along with other issues of normal adolescent and adult developments. That is, to treat the client as an ordinary person with individual needs and issues.

- From the authors’ clinical experiences  
- From Ref [94]  
- From Ref [22]  
- From Ref [96]  
- From Ref [97]  
- From Ref [98]  
- From Ref [99]
heterosexuals to prepare for their coming-out and to help their parents work through such a difficult period is already available in Taiwan [101].

For family works after coming-out, therapeutic models have been addressed [102, 103] with the following principles. They include to foster a supportive family for the youth, to reduce the families’ guilty feeling and shame, to reduce families’ negative stereotypes and anticipation associated with non-heterosexuality by providing correct information, to help maintain affective connection within family and avoid blaming the youth, and to support the youth and the families to discover the positive aspects of the experiences being non-heterosexual. Parents may anticipate that their children will live miserable lives as long as they are not heterosexual. Therefore, therapists should clearly challenge those irrational presumptions, give ample supports and instill hope. To introduce the families to the counseling hotlines and peer-support groups (e.g. Taiwan Tongzhi Hotline Association, http://www.hotline.org.tw) is often helpful.

Specific material addressing couple relational issues is available [104]. The effects of gender socialization and internalized homophobia on the development of intimacy should be carefully addressed. Therapist’s affirmation to the couple relationship is helpful for the well-being of the non-heterosexual individuals and for strengthening their partnership and mutual supports.

Conclusion

Non-discriminative and affirmative stances are essential for psychological and medical care for non-heterosexual individuals. To improve understanding, to facilitate ethical and non-biased quality care, and to promote well-being for non-heterosexual people in Taiwan, we make the following suggestions to the Taiwanese mental health community. (A) We should conduct more research on non-heterosexuality, including local demographics, identity developments and mental health conditions, influences from anti-homosexual prejudice, and issues of same-sex partnership. (B) We are responsible for ensuring non-biased and non-harmful care for non-heterosexual individuals seeking help from mental health services. This effort could be achieved by the advocacy of affirmative stance, and by the professional societies’ official claims (e.g., the “Position Statement” [2, 3, 105-111]), which are currently not available in Taiwan. (C) We are responsible for distributing these knowledge and perspectives to our colleague health care providers. (D) We should join the advocates supporting legal equality (e.g. marriage equality) for non-heterosexual people, to promote their well-being and to strengthen their resilience.

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緒說摘要

非異性戀：當代精神醫學觀點

賴孟泉¹ ² 高淑芬¹ ³ 丘彥南¹

雖然自 1973 年始，同性戀 (homosexuality) 已經自精神醫學診斷中「去病理化」，但人類社會對於非異性戀 (non-heterosexuality) 之性傾向、性行為、與性認同外顯或內隱的偏見與歧視仍持續存在。這些偏見源自社會中具優勢地位的異性戀主義 (heterosexism) 價值體系，更因人們對於性特質 (sexuality) 之多樣性及多元本質的誤解而被增強。在過去數十年間，經由許多精神健康專業工作者、心理學家、社會科學家、生物學家、以及不同學門之性別研究者的致力探究，已累積許多對於非異性戀的瞭解。而這些知識將能增進我們對於人類性特質的理解，並可能藉之降低長期以來對於異性戀的偏見與歧視。本文以精神醫學觀點，回顧目前關於非異性戀議題的知識。首先簡介非異性戀的定義與概念架構，並摘要整理人口學資料及生物學發現；其次闡述四項重要的心理學議題，包括認同發展、異性戀主義及內化同性戀恐懼 (internalized homophobia)、精神健康及自殺議題，以及同性伴侶關係；最後簡要回顧與非異性戀個體及其家人進行心理治療工作之議題。本文結論向臺灣精神健康工作社群提出四項關於非異性戀議題之建議：

1. 努力提高關於臺灣非異性戀個體的正確認識與理解；
2. 採用肯定性立場 (affirmative stance) 以確保進行不帶偏見、且不具傷害性的臨床工作；
3. 將這些知識與觀點傳遞予其他健康照護工作者；
4. 支持並促進臺灣非異性戀個體及社群在法律上所應接受的平權對待。

關鍵詞：性特質，同性戀，非異性戀，發展心理學

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