

SEXUAL ORIENTATION AND MENTAL HEALTH: INCREMENTAL PROGRESSION OR RADICAL CHANGE?

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ABSTRACT

This manuscript provides a critical historic analysis of the status of sexual orientation nondiscrimination within the context of the mental health profession. The declassification and reclassification of homosexuality in the Diagnostic and Statistical Manual of Mental Disorders is addressed. While the DSM reclassifications represent a slow shift toward the acceptance of homosexuality within the fields of psychiatry and psychology, the APA of the present represents a radical shift from the past.

INTRODUCTION

There has been a surge of optimism among social equity advocates in recent years as our society appears to be on a trajectory towards equality, particularly within the LGBT community. In 2010, President Obama issued a memo extending benefits to same-sex domestic partners of federal employees. In 2013, the U.S. Supreme Court issued the “Rainbow Rulings” (*Hollingsworth, et al., v. Kristin M. Perry* and *United States v. Windsor*) which upheld marriage equality in California and ruled the federal Defense of Marriage Act (DOMA) as unconstitutional. Each year additional states are added to the list of jurisdictions that allow same sex marriage—the District of Columbia and seventeen states²⁸ provide full marriage equality. In

²⁸ CA, CT, DE, HI, IA, IL, ME, MD, MA, MN, NH, NJ, NM, NY, RI, VT, WA
(Source: [Freedomtomarry.org](http://freedomtomarry.org))

addition, the significance of the *Windsor* decision expands beyond ruling DOMA unconstitutional to extending federal benefits to *all* same-sex married couples, regardless of state, where the federal government has jurisdiction (e.g. bankruptcy, visitation rights in federal prisons, survivor benefits, and the right to refuse testimony against a spouse) (Perez, 2014).

In contrast, discrimination based upon sexual orientation is pervasive in American Society. Thirty states have legislation that specifically prohibits same-sex marriage (FreedomToMarry.org, 2014). Numerous reports on the LGBT community provide evidence of bullying, harassment, and discrimination in employment (Swan, French, & Norman-Major, 2012). Reported hate crimes against lesbians, gays, and bisexuals increased 6% (1, 265) between 2006 and 2007 (Marzullo & Libman, 2009). Individuals who identify as LGBT have reported discrimination in the provision of health care services. A survey administered in 2009 by Lambda Legal reveals:

More than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive (“When Health Care Isn’t Working”, 2010).

Furthermore, a study by Hatzenbuehler, Keyes, and Hasin (2009) found that mood and anxiety disorders were more prevalent among gays and lesbians in states without protective policies for the LGBT community.

Given the juxtaposition of the status of gays and lesbians, this manuscript provides a critical historic analysis

of the status of sexual orientation nondiscrimination within the context of the mental health profession.

THE MARGINALIZATION OF HOMOSEXUALITY

The mainstream view in American society today is that religion, particularly Christianity, condemns homosexual behavior, however, lively debate continues over the interpretation of Biblical texts. For example, some scholars point out that the word *homosexual* did not enter the English language until 1912 nor was the term included in the Bible until the “1946 RSV in Corinthians 6:9” (Everding, n.d.). There is also an ideological divide over homosexuality among denominations and churches ranging from acceptance and support of lesbians and gays (e.g. Unitarian Universalist) to active hostility (e.g. Southern Baptist).²⁹ The most extreme examples of active hostility toward gays and lesbians in recent times are displayed through Westboro Baptist Church (unaffiliated Baptist) in Topeka Kansas. Westboro members protest at funerals and various other events with their notorious signs “God hates fags.”

Although religion continues to be a major influence on society’s perception of homosexuality, the purview of homosexuality shifted from religious doctrine to institutions of authority in the late 19th century via law and medicine, particularly the field of psychiatry (De Block & Adriaens, 2012; Drescher, 2010; Foucault, 1976/1990; Wahlert, 2013). The embedded cultural values and norms within a society at any particular point in time shape our way of thinking and locks us into cultural paradigms. Foucault (1976/1990) contends that homosexuality

²⁹ The Southern Baptist Faith and Message, XV “The Christian and the social order”, includes specific language opposing homosexuality. See <http://www.sbc.org/bfm/bfm2000.asp>

categorized as an unnatural act that requires punishment or treatment is a social construct. He states:

We must not forget that the psychological, psychiatric, medical category of homosexuality was constituted from the moment it was characterized—Westphal’s famous article of 1870 on ‘contrary sexual sensations’ can stand as its date of birth...homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny...The sodomite had been a temporary aberration, the homosexual was now a species (p. 43).

When a behavior is characterized as outside of the norm the individuals who engage in such behavior become marginalized to the status of “other” within society. Psychiatrists in France were paid by the government to address mental illness, including homosexuality (De Block & Adriaens, 2012) and the American Psychiatric Association classified homosexuality as a mental illness in the first publication of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952. Specifically, homosexuality was placed in the rubric of “sexual deviation” and categorized as a “sociopathic personality disturbance” (Mendelson, 2003). The foundation of social control through the medical model is established when homosexuals, labeled as sexual deviants in DSM-1, sought treatment. Treatment for homosexuality included lobotomies, pharmaceuticals, various aversion therapy experiments, and psychoanalysis (Ault & Bruzzy, 2009).

INCREMENTAL PROGRESSION

Most mental health professionals were slow to embrace studies that countered evidence of alternative sexual behavior as “normal.” It is important to note that the first Kinsey Report, *Sexual Behavior in the Human Male*, was published in 1948 prior to the DSM I. Among the 12,000 male participants in the study, 37% had at least one homosexual experience as an adult and 20% had just as many homosexual as heterosexual experiences (Mohr, 1995). Nevertheless, the field of psychiatry was hostile to the Kinsey report results and the notion that homosexual behavior occurred more frequently than previously thought (Drescher, 2010). The refusal to accept homosexuality as normal is further illustrated in the experience of Dr. Evelyn Hooker. In 1953, Dr. Hooker received a grant from the National Institute of Mental Health to study homosexuality. In her reflections on the reactions of individuals she contacted to serve as a psychiatric consultant for the study, she stated:

I went to see the chair of the Psychiatry Department. When he asked me about the research, I told him I was studying “normal male homosexuals.” He rose from his chair and said, “What do you think you are doing? There is no such person.” He then referred me to Frederic Worden, who had just come to the department. I let Dr. Worden read my application. He, then turned to me and said, “I have never seen such persons, but I sure would like to” (p. 450).

The participants of Dr. Hooker’s study, 30 homosexual males and 30 heterosexual males, were administered the Rorschach test, Thematic Apperception Test (TAT), and Make-A-Picture Story (MAPS). She then developed matched pairs controlling for age, IQ, and

education and submitted the results to “experts” within the field for assessment. The “experts” were unable to determine the sexual preferences of either individual in each of the matched pairs. The results of the study were a contributing factor to the eventual removal of homosexuality as a mental illness in the DSM. Nevertheless, in 1968 the DSM II only differentiated ‘sexual deviation’ from ‘personality disorders’—with homosexuality included under sexual deviation.

DSM Classifications

The 1970-1972 annual meetings of the APA included significant events that eventually led to the removal of homosexuality from the DSM. Gay and lesbian activists disrupted the 1970 APA conference in San Francisco followed by a massive demonstration at the 1971 conference in Washington, D.C. (The Rainbow History Project, n.d.). At the 1972 APA conference, Dr. Fryer spoke to the audience about the frustration and predicament of being gay in a profession that labels homosexuals as mentally ill—he used voice distortion, a wig, and a mask to conceal his identity (Kirby, 2003).

Although the word homosexuality was removed from the DSM-II in 1973 as a psychiatric disorder, it was repackaged and relabeled in DSM-III. The classification of homosexuality was replaced with “sexual orientation disturbance” (De Cecco, 1987; Kirby, 2003). In addition, while the declassification of homosexuality was supported by an official position statement of the APA, the association still considered homosexual behavior to be outside of the norm:

No doubt, homosexual activist groups will claim that psychiatry has at last recognized that homosexuality is as ‘normal’ as heterosexuality. They will be wrong. In removing homosexuality per se from the nomenclature we are only recognizing that by itself homosexuality does not

meet the criteria for being considered a psychiatric disorder. We will in no way be aligning ourselves with any particular viewpoint regarding the etiology or desirability of homosexual behavior (APA, 1973, pp. 2-3) (as cited in Drescher, 2010, p. 435).

An Ad Hoc Committee against the Deletion of Homosexuality was established during the professional debates within the APA. The Ad Hoc Committee held the belief that homosexuality was pathological and the decision to remove it from the DSM was motivated by recent political activism among gays and lesbians both internal and external to the profession. Furthermore, “Many of the specialists, however, were invested in the construct’s continued use and therefore biased with the respect to the outcome (they did not want their specialty area eliminated)” (Zachar & Kendler, 2012, p. 6).

The decision to declassify homosexuality as sexual deviation and reclassify as “sexual orientation disturbance” was a compromise for the APA members who favored removing homosexuality from the DSM (Zachar & Kendler, 2012). When the APA Board of Trustees rendered the decision to remove homosexuality from DSM II, leading opponents garnered 234 signatures on a petition demanding full referendum of the membership regarding the status of homosexuality (Zachar & Kendler, 2012). Controversy continued within the APA over “proper” classification of homosexuality. In 1980, DSM-III replaced sexual orientation disturbance with a new category “ego-dystonic homosexuality” (Kirby, 2003). In 1987, the category of “ego-dystonic homosexuality” was relabeled in the DSM-III-R as “sexual disorder not otherwise specified” (De Cecco, 1987; Kirby, 2003). Some scholars contend the DSM-III-R removes homosexuality—while it does remove the word homosexuality, treatment is still provided. The

category was relabeled “sexual and gender identity disorders” in the 1994 publication of the DSM-IV and the 2000 revision—DSM-IV—TR still included “sexual disorder not otherwise specified- 302.9” under the Gender Identity Disorders Section. The category includes sexual disturbances that are neither disorders nor dysfunctions, however, an example specifically provided is “persistent and marked distress about sexual orientation” (Mendelson, 2003). The most recent DSM-V, published in 2013, removes sexual orientation and reclassifies “gender identity disorder” as “gender dysphoria” (“Highlights” 2013, p.15). The Gay Lesbian Medical Association (GLMA) issued the following statement on the classification in DSM-5:

While there is still more work to be done to ensure stigmatizing labels are not associated with transgender people, the terminology and definitions used in the DSM-5 represent a shift toward recognizing that transgender people, like lesbians, gay men and bisexuals, should not be pathologized simply for who they are (n.p.)

Therapy

If homosexuality is truly accepted as “normal” within the mental health profession then why is treatment still offered today? The creation of the Gender Identity Disorder classification, particularly GID in children, was perceived by many APA members as “an attempt to prevent adult homosexuality via psychiatric intervention with children” (Zucker & Spitzer, 2005, p. 34). It is also worth noting that the GID classification was introduced in DSM-III when the word homosexuality was removed.

The majority of participants in the early studies on sexual orientation change efforts (SOCE), also known as reparative or conversion therapy were mandated via court order (APA Task Force, 2009). Nevertheless, stigma resulting from community, religious, and familial rejection

of homosexuality, is a major factor for individuals who seek to change their sexual orientation (APA Task Force, 2009). Methods for sexual orientation change efforts (SOCE) vary to include psychotherapy, support groups, and nontraditional experiments. Providers range from licensed and unlicensed mental health professionals to religious counselors. Despite the continuance of SOCE programs, the APA issued a position statement in 1998 on reparative or conversion therapies:

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...In recent years noted practitioners of 'reparative therapy' have openly integrated older psycho-analytic theories which pathologize homosexuality with traditional religious beliefs condemning homosexuality (in Kirby, 2003, p. 675).

The increased number of religious organizations that offer SOCE since the initial declassification of homosexuality by the APA represents a shift back from the medical model to religious organizations as an institutional control of homosexuality in society. Founded in 1992, the National Association for the Research and Therapy of Homosexuality (NARTH) was established to represent members of the mental health profession who continued to view homosexuality as a mental disorder that requires treatment. NARTH served as springboard for numerous Christian Right organizations (e.g. Traditional Values Coalition, Concerned Women for American, Focus on the Family, the Family Research Council, the 700 Club, etc) with an anti-gay/lesbian agenda ("The Ex-Gay Movement," n.d.). A survey of over 400 gays and lesbians who had participated in conversion therapy programs found that

many individuals quit SOCE therapy due to depression and suicidal thoughts (Rix, 2013).

RADICAL CHANGE

The initial treatment of gays and lesbians by the mental health profession leaves remnants of intolerance and ignorance within American society. While the DSM reclassifications represent a slow shift toward the acceptance of homosexuality within the fields of psychiatry and psychology, the APA of the present represents a radical shift from the past. In the 2009 task force report, *Appropriate Therapeutic Responses to Sexual Orientation*, the APA rejects SOCE and embraces the importance of cultural competence and evidence-based treatment:

Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has provided evidence of efficacy, has the potential to be harmful, and delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. Rather, therapy that increases the client’s ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach (p. 6).

The task force reported that there is not enough evidence to support any claims that SOCE programs are effective and that such programs may, in fact, be harmful. The APA Resolution, *Appropriate Affirmative Responses to Sexual Orientation*, reaffirms their position on nondiscrimination and indicates that same-sex attractions are “normal and positive variations of human sexuality regardless of sexual orientation” (APA Task Force, 2009,

p. 121). The resolution also encourages collaboration between mental health professionals, religious organizations, and policy makers. At the time of this writing only two states, New Jersey and California, have outlawed conversion therapy programs for minors (Walhert, 2013). However, Massachusetts, New York, and Ohio also have pending legislation that would ban conversion therapy (Victor, 2014).

The APA Task Force Report (2009) recommends affirmative therapeutic interventions that include the following elements: acceptance and support, comprehensive assessment, active coping, social support, and identity exploration and development (Table 1).

Table 1
Elements of Affirmative Therapeutic Interventions

Elements	Characteristics
Acceptance and Support	Empathy, openness, encouragement
Comprehensive Assessment	Awareness, countering stigma and stereotypes
Active Coping	Strategies to reframe conflict
Social Support	Psychotherapy, self-help groups, or welcoming communities
Identity Exploration and Development	Active process of self-exploration that addresses identity conflicts

(Source: APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). *Report of the Task Force on Appropriate therapeutic responses to sexual orientation*, p. 86)

Cultural Competence

The importance of cultural competence is found at the intersection of mental health, public policy, and public administration. The passage of the Affordable Care Act, the repeal of *Don't Ask Don't Tell* and the *Windsor* decision have a direct impact on the provision of services and highlights the need for cultural competence in the provision of services. Discrimination and its impact on the LGBT

community justify the need for culturally competent public administrators (Swan et al, 2012). Borrego (2013) compares the progression of cultural competence frameworks to better serve minorities as similar to progression of cultural competence to serve LGBT community. Swan and colleagues (2012) also point out that the public sector occasionally takes the lead in the expansion of civil rights; therefore, it is important to include the needs of the LGBT community when establishing a framework for cultural competence.

The U.S. Department of Health and Human Services (HHS) is working toward improving access and quality in health care services for the LGBT community—this includes nondiscrimination via the Affordable Health Care Act and enhancing services to meet the needs of gays and lesbians. Within HHS, the Health Resources and Services Administration has expanded training on cultural competency in LGBT health care, the National Institute of Health held a symposium on health research relevant to the LGBT community, and the Substance Abuse and Mental Health Services Administration developed a resource document for practitioners who work with LGBT youth (“HHS LGBT Committee Report”, 2013). In addition, Healthy People 2020 has included the goal to “Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender individuals” and is working to increase data systems that include the LGBT community to better address health disparities.

CONCLUSION

To claim that it has been four decades since the declassification of homosexuality as a mental illness in the DSM is factual, but misleading since homosexuality was reclassified through several versions of the DSM. The most recent DSM, along with accepted practices within the

mental health profession represents a radical shift. Nevertheless, while the U.S. Department of Health and Human Services and the mental health profession focus on reducing institutional discrimination through policies and practices that promote cultural competence within the LGBT community, discrimination persists within our broader society. We will achieve true equality when individuals no longer feel compelled to seek therapy due to a heterosexual discourse that marginalizes gays and lesbians.

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