Examination of the Removal of Homosexuality From the DSM

Cherliz Cohen

Wagner College, Department of Psychology

Table of Contents

page

Abstract

In 1952, identifying as gay was seen as a mental disorder rather than a sexual orientation within the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Mental health professionals were attempting to "cure" the feelings gay individuals had towards the same sex by harmful therapies referred to as aversion therapy. Men in particular, many wanting to be "cured," were put through electro-shock therapies and studies where they made to be nauseous and sick after viewing images or film of other men. All in all, over sixty years of work by gay rights activists, psychiatrists, psychologists, and leaders in the mental health community has ultimately shaped the way individuals from sexual minority communities are viewed and cared for by medical professionals. After the initial addition to the DSM-1, and the use of aversion therapy to treat LGBTQ+ populations, there are now safe and effective therapies to assist LGBTQ+ individuals with their mental health. Studies done by researchers such as Hooker and Kinsey's assisted in the eventual removal of homosexuality from the DSM. The position Davison carried, being one of the first to talk against unethical therapies on gay populations in conference, also contributed to the eventual removal as well. After studies, conferences, and protests, the DSM finally had its final removal (2013) of all terms that could overlap with homosexuality.

Keywords: gay, mental health, men, dsm, therapies, removal, homosexuality

Homosexuality and the DSM

In 1952, identifying as gay was seen as a mental disorder rather than a sexual orientation as per the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Mental health professionals attempting to "cure" the feelings gay individuals had towards the same sex, performed various harmful therapies, such as aversion therapies. By undergoing these therapies, individuals, mostly being men, underwent electro-shock therapies and studies where they were made to feel nauseous and sick. Following important studies run by professionals such as Kinsey and Hooker, as well as activists and media pushing the opposite message, the idea of "homosexuality" being a mental disorder was completely removed from the DSM-V in 2013. In this outline, I'll be exploring research and data's effect on homosexuality within the DSM, focusing on the evolution throughout the editions (I-V), and eventual removal. It's important to note that while the term homosexuality was removed from the DSM in earlier editions, terms that overlap with homosexuality did have a place in the DSM until 2013.

Homosexuality's Entry Into the DSM

In the mid-20th century, theories regarding adult homosexuality as a disease, deviating this population from "normal" heterosexual development, began to spread. These theories hold that some internal defect or external pathogenic agent causes homosexuality in an individual, which was seen as "morally bad" and "socially evil" (Drescher, 2015). During this time, American psychiatry was greatly influenced by psychoanalytic perspectives and theories, such as many regarding individuals identifying as homosexual. In 1952, when the first APA published the first edition of the Diagnostic and Statistical Manual (DSM-I), it listed all conditions psychiatrists then considered to be a mental disorder.

DSM-I

Upon publishing, the DSM-1 classified "homosexuality" within the larger "sociopathic personality disturbance" category of personality disorders (American Psychiatric Association, 1952). The sexual deviation diagnosis includes "homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation)" as examples.

DSM-II

While the DSM-I included uncertainty in terms of whether homosexuality was a disorder, the DSM-II removed that uncertainty and clearly presented homosexuality and the other "sexual deviations" as mental disorders (American Psychiatric Association, 1968). These deviations were listed under ten individual diagnostic codes such as: homosexuality, fetishism, transvestitism, exhibitionism, voyeurism, sadism, masochism, other sexual deviation, and unspecified sexual deviation. It describes as follows: "This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances…. This diagnosis is not appropriate for individuals who per- form deviant sexual acts because normal sexual objects are not available to them."

The DSM-II's initial release created an uproar of activists and professionals storming APA conferences and protesting homosexuality's addition to the DSM. Following the riots and activism, Robert Spitzer, a technical consultant, and writer for the DSM-II Committee, began a go-between in this dispute. Spitzer originally believing that homosexuality had its place in the DSM, he later met with a group of activists, including a secret group of gay APA members, and was faced with data from researchers such as Alfred Kinsey and Evelyn Hooker (De Block & Adriaens, 2013). Facing the data and concerns of his colleagues and other professionals in the field, he drafted the compromise of removing homosexuality itself from the DSM. The removal

was subject to a revision of "sexual orientation disturbance," defined not just as same-sex attraction but as a conflict caused by this attraction or a desire to change it. After a vote by the APA board of trustees, this change was made.

DSM-III

The DSM II noted that homosexuality by itself did not establish as a psychiatric disorder. A later edition of the DSM was published in 1980, the DSM-III, renaming "Sexual Orientation Disturbance" as "Ego Dystonic Homosexuality" (American Psychiatric Association, 1980). Upon a revision, the DSM-III was later revised, categorizing marked distress about one's sexual orientation under "sexual disorder, not otherwise specified" (American Psychiatric Association, 1987).

Alfred Kinsey and the Kinsey Report

Four years prior to the initial publication of the DSM-I, the first Kinsey Report, which concerned sexual behavior in both the human male and female, was published by Alfred Kinsey. Kinsey and his fellow researchers sought to accumulate unbiased information regarding sex, employing firsthand interviews with both heterosexual and homosexual identifying individuals, to gather such data. The report featured contents such as: homosexual, and heterosexual petting and outlets. Several subcategories can also be found such as bisexuality and masturbation.

Kinsey's Study

The Kinsey Report's first edition consisted of a report that has been referenced in many studies regarding homosexuality, investigating the evolution of the term and population throughout the years. The report found that in terms of physical contact to the point of orgasm, at least 37% of the male population had "some homosexual experience" between the beginning of adolescence and old age (Kinsey et al., 1948). Additionally, the remaining who were unmarried

until a certain age, exactly 50%, "have homosexual experience" between the beginning of adolescence and old age. While receiving this data through a study, the psychiatry field was hostile to Kinsey's report, as well as the implications that same-sex sexual behavior was in fact more common than society and researchers had previously believed.

The Heterosexual-Homosexual Rating Scale

The Heterosexual-Homosexual Rating Scale, more commonly known as The Kinsey Scale, which can also be found in the Kinsey report, accounted for research findings that showed individuals did not fit into exclusive heterosexual or homosexual categories. The scale helped weaken the idea of homosexuality as a fixed condition, providing large-scale evidence about the differential social distributions and organization of same-sex experience (Nardi & Schneider, 1997). The research gathered showed that sexual behavior, thoughts, and feelings towards either the same or opposite sex were not always consistent. Instead of assigning people to three categories – heterosexual, bisexual, and homosexual, Kinsey and his team used a seven-point scale, ranging from 0 to 6 with an additional category of "X."

People at: "0" report as entirely heterosexual, "1" as largely heterosexual but with incidental homosexual history, "2" as largely heterosexual but with a distinct homosexual history, "3" as equally heterosexual and homosexual, "4" as largely homosexual but with distinct heterosexual history, "5" as largely homosexual with incidental heterosexual history, and lastly "6" as entirely homosexual (Nardi & Schneider, 1997). Additionally, Kinsey and his team included "X", reporting as unresponsive to either sex.

The publication of this report, and later the second edition, caused a "media explosion" as quoted in the Los Angeles Times. News outlets ran stories on the published report, while church leaders denounced it. Kinsey's work reassured individuals questioning their sexuality that they

were not alone; highlighting a disconnect between certain laws of the land and actual sexual practice (Mestel, 2004). “Everybody’s sin is nobody’s sin.” said Kinsey, a line quoted often in reports and articles concerning himself and his studies on sexuality.

Evelyn Hooker

Influenced by a former student by the name of Sam From, whom Evelyn Hooker developed a close friendship with Hooker began an investigation that would ultimately result in the removal of homosexuality as a form of psychopathology from the DSM (Milar, 2011). From informed Hooker that it was her “scientific duty” to study homosexuals, promising her access to all subjects needed to carry the study out. While she initially demurred the idea, she was later persuaded by From and her colleague Bruno Klopfer.

Only 5 years after the publication of the DSM-1, the study took place, investigating the comparison between happiness and the well-adjusted nature of 30 self-identified gay men with 30 heterosexual men, finding no difference (Hooker, 1957). For this study, Hooker gathered the participants’ results for the Rorschach Test, Thematic Apperception Test (TAT), and Make-A-Picture Story (MAPS). Following the results, she matched pairs, controlling for their age, IQ, and education, before submitting all results to “experts” within the field. These “experts” were unable to determine the sexual preferences of any individual in each of the matched pairs. Meaning, the experts found no association between homosexuality and psychological maladjustment. One of the experts, who was sure he can distinguish the groups, asked for another chance to review the pairings but was no more successful the second time than he was the first. Hooker’s results suggested that those claiming homosexuality was a mental disorder were drawing a “false correlation” by only studying homosexuals who had a history of mental illnesses (Anteby & Anderson, 2014).

This ground-breaking research not only left a long-lasting impact on how people viewed homosexuality, and the changed made in the DSM, but also the effect it had on homosexuals at the time of its release. Following the research, Hooker was awarded the *Distinguished Contribution to Psychology in the Public Interest* award from the APA. In response to this honor, she shared the award with the gay and lesbian community, expressing how pleasurable it had been for her research and her "long advocacy of a scientific view of homosexuality" could better the lives of homosexuals and their families (Milar, 2011).

Playboy, Ethics, and Gerald Davison

Gerald Davison is seen by many as the first domino to fall in science's ultimate disowning of the "gay cure" (Abumrad, 2018). Taking an interest in Sigmund Freud at an early age, this led Davison to gain multiple degrees in both Psychology and Social Relations. Following his PhD, he began teaching, supervising a variety of cases regarding LGBTQ+ individuals, mostly gay men, during his free time. These men were unhappy with their attraction to the same sex and asked Davison to "turn them." Not wanting to impose his heterosexual values on these patients, while also being against harmful therapies used by others such as aversion therapy (electro-shock therapy), Davison came up with an alternative approach.

Playboy Therapy

Davison along with many therapists around the country were experiencing a high volume of patients wanting to "fix" their sexual orientation. The overall approach did not start with Davison alone, though. Other therapists used behavioral therapies with LG (lesbian and gay) identifying clients, most being aversion therapy, also known as electro-shock therapy. Many even nauseated their patients with injections for results or shocked the idea of men "out" of the patient.

After attending a guest-speaker even at Stony Brook held by M. P. Feldman and watching the film they displayed of aversion therapies they ran, Davison was bewildered (Abumrad, 2018). One example of the film shown was a male identifying patient being shown photos of other naked men, and after each photo, Feldman shocked the patient. Davison was against Feldman's treatment of purposely inflicting pain on patients and thought "Do we really have to do it this way? Are there other ways to do this?"

Taking the basic idea of aversion therapy and completely transforming it, where instead of shocking the image of men out of a man, he would gently encourage positive gay thoughts, and map them onto another body. Davison asked his patients to find a copy of Playboy Magazine, what he found to be a source of material of attractive women. He instructed them to "masturbate with the homosexual image", then at that point of a possible climax, to switch over to the images of women, and climax. Meaning, instead of shocking the image of men out of a man, he'd gently encourage positive gay thoughts, and map them onto another body. Davison defined this as "orgasmic reorientation." This approach seemed to work, proving itself as effective for the patient after a few "sessions" (Abumrad, 2018). Following its success, many medical professionals adopted his therapy and used it with their patients wanting the same outcome.

Ethical Issues

In 1972, Davison became the youngest president of the Association for the Advancement of Behavior Therapy. After attending several conferences, where other therapists showed film of aversion therapies they put their gay participants through for studies, he was hit with a realization (Abumrad, 2018). His presidential address, still spoken about today in documentaries, podcasts, and other publications, would change the way people discuss homosexuality and the way they

view him. Addressing all therapists, as well as the audience who sat before him, he revealed that he had some concerns regarding *ethical issues* that he has been "wrestling with for years" regarding how homosexuality is approached in studies and therapeutic settings (Abumrad, 2018). He asks, "what does it actually mean to help these people?" (Caruso, 2022). Davison then highlights that the problem that gay identifying men are asking therapists, including himself, to solve is a problem that they created and labeled as a problem. Following this, he then asks "Even if we could affect certain changes, there is still the more important question of if we should… I believe we should not." The room was silent, before being met with a short applause. Afterwards, Davison was ignored by most. He did admit that some people did come around (Abumrad, 2018).

These ethical issues he had concerns about were further investigated in his paper published in 2001. The paper reviewed several conceptual and ethical issues surrounding the study and treatment of gays, lesbians, and bisexuals, with an emphasis on the overlooked political and ethical aspect of what therapists choose and are allowed to treat, towards the goal patients themselves want to work towards. Davison discusses both relevant and irrelevant issues concerning sexual orientation and the role of therapist biases in assessing and treatment planning, the need for better understanding of how LGB (lesbian, gay, bisexual) patients are construed and the associated risks of stereotypes, the challenges of coming out and the way therapists can help patients make and implement improved choices, the deleterious effects these can have on them, and more (Davison, 2001).

Removal of Homosexuality from the DSM

Over sixty years of work by gay rights activists, psychiatrists, psychologists, and other leaders in the mental health community had ultimately shaped the way individuals from sexual

minority communities are viewed and cared for by medical professionals. Following the initial addition to the DSM-I and its eventual removal in 2013, we can safely say that aversion therapy isn't a common practice used to treat homosexuality. Subsequently after Kinsey, Hooker, Davison, and several other mental health professionals' studies and publications, as well as protests happening throughout this time on the streets and within conferences took place to remove homosexuality from the DSM, the DSM-IV, and later DSM-V was published. The DSM-V, finally removing homosexuality as a diagnosis that can be "cured."

DSM-IV

Following the publication of the DSM-IV, homosexuality was removed all-together, while still including terms that can overlap. The distress over one's same-sex sexual orientation and identity remained in the manual, under different names, such as "transsexuality" and GID (gender identity disorder), up until the DSM-V (American Psychiatric Association, 1994). This shift in focus highlights the importance of cultural context in which a diagnosis may be made (McHenry, 2022).

DSM-V

As noted within the DSM-V, cultural normatives have had an impact on what is considered pathological, and as norms shifted during the gay rights movement, so did the conceptualization of homosexuality (McHenry, 2022). Upon the release of the fifth edition, homosexuality's removal stayed in place while GID, and other terms that may overlap with the term homosexuality had been removed (American Psychiatric Association, 2013). The DSM-V did not include any diagnostic category that can be applied to people based on their homosexual orientation, though it does include a separate, non-mental disorder diagnoses of gender dysphoria

to describe the significant distress individuals may feel with the sex and/or gender they were assigned at birth.

Conclusion

Studies such as those performed by researchers such as Hooker and Kinsey assisted in the eventual removal of homosexuality from the DSM. The position Davison carried, being one of the first to talk against unethical therapies on gay populations in conference, also contributed to the eventual removal as well. After studies, conferences, and protests, the DSM finally had its final removal in 2013, eliminating all terms that can overlap or connect to homosexuality. The APA's diagnostic revisions made throughout the years was the beginning of the end of organized medicines official participation in the social stigmatization of homosexuality as we know it today. Similarly, shifts progressively took place in various fields and other mental health communities. Because of this, debates about homosexuality shifted away from medicine and psychiatry and into more political and moral realms. In doing so, cultural attitudes about homosexuality changed in several countries, normalizing their views on homosexuals and homosexuality.

Most importantly, because of the modifications seen in the field and within the DSM and removing the diagnosis of homosexuality, this led to an important shift from asking questions about "what causes homosexuality?' and "what is the cure to homosexuality?" to focusing instead on the health and mental health needs of LGBTQ+ patients and populations. Mental health and other medical professionals can attend conferences and take courses and other sorts of training throughout or after, receiving their degrees, providing more insight on how to treat minority populations such as the LGBTQ+ community.

An Examination of the Literature on Evidence-Based Therapy Modalities for LGBTQ+ Populations

Data collected in 2021 by New York City's Department of Health found that an estimated 7.1% of adults in the United States identify as a member of the LGBTQ+ community (New York State Department of Health, 2022). LGBTQ+ is an acronym for lesbian, gay, bisexual, transgender, and queer or questioning. While homosexuality is not a mental disorder (and has not been considered as such since the DSM-II), data does suggest that people within the LGBTQ+ community experience higher rates of some mental health conditions (Whaibeh et al., 2019). To better understand why LGBTQ+ adults are more susceptible to mental illness than cisgender/heterosexual adults, we will explore the prevailing academic literature on mental illness within the LGBTQ+ community and look to research which has studied the effectiveness of several psychotherapy treatment modalities when used to treat adult members of the LGBTQ+ population.

Theory

Modern-day research has established that homosexuality is not a mental disorder; it cannot be "treated" or "fixed". LGBTQ+ individuals do, however, on average experience more mental health adversities than cisgender/heterosexual people. There are several explanations for this overrepresentation of mental illness in the LGBTQ+ population. For one, LGBTQ+ individuals are often scrutinized by family/peers for their gender identity/sexual orientation starting at a young age. Despite the push we see today for widespread acceptance of LGBTQ+ identities, there is still an abundance of homophobia/transphobia ingrained into our society, causing stress and other mental health issues to the population. As such, many LGBTQ+ people (especially adults/elders) have likely been exposed to a significant amount of discrimination

throughout their lives for their identities. In turn, these people may internalize discriminatory remarks made against them, leading to diminished self-esteem, depression, anxiety, shame, and other negative feelings surrounding their gender identity/sexual orientation. Because of this, the focus of therapy for LGBTQ+ individuals should primarily be about helping them to feel confidence and pride in their identity and unlearn societal expectations for gender/sexuality. Essentially, a therapist working with a homosexual client would not aim to treat the homosexual feelings; instead, they would work to alleviate the negative feelings the client has about their sexual orientation because of societal stigma/internalized homophobia.

Minority stress theory has illustrated how experiences such as those listed above have caused stress, translating into health disparities for sexual and gender minority populations. This theory suggests that sexual minorities, underrepresented gender identities, and other sexual identities apart of the LGBTQ+ population experience chronic stressors related to their identity. Having to experience discrimination and oppression can lead to the feeling of stigmatization, putting those at a higher risk for developing mental health disorders.

The psychodynamic theory on the other hand covers the mental processes one may develop in the early stages of their life and the effect it may have on their behavior and mental states. An example of this would be an anxiety disorder development in the future for a queer child who received a negative reaction from their parents when coming out. Acts of homophobia and other types of discrimination can lead to lasting effects in the future.

Review of Literature

Debunking Conversion Therapy

In the past, conversion therapy techniques were very popular among mental health clinicians and were used in attempts to turn those attracted to the same sex, heterosexual or make

people with gender dysphoria feel comfortable in their sex assigned at birth. Conversion therapy was masked with alternative names such as sexual reorientation therapy (SRT), sexual orientation change efforts (SOCE), ex-gay therapy, or gender identity change efforts (GICE). Once homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders, also known as the DSM, and no longer considered a mental disorder, its popularity began to drastically decline; this is especially true as more research supported the notion that homosexuality is unchangeable, and conversion therapy techniques are ineffective (Higbee et al., 2022). Despite this, some people still attempt to facilitate conversion therapy today. Techniques range from painful aversion therapies, electric shocks, chemical castration, to (in extreme cases) corrective rape. However, more commonly conversion therapy focuses on prayer, talk, and therapy that attempts to diminish the individual's same-sex attraction or gender expression through humiliation and forced adherence to strict gender roles (Higbee et al., 2022).

Homosexuality had not been considered a mental disorder in the DSM since 1973, and in 2013 gender nonconformity underwent a similar change from "gender identity disorder" to "gender dysphoria," implying that being either non-binary or transgender does not present as a mental disorder (American Psychiatric Association, 2013). That all being said, conversion therapy is still being exploited by religious leaders and groups and select mental health practitioners as a form of social control (Higbee et al., 2022).

Conversion therapy has been scientifically proven to be ineffective, leading to significant, long-term psychological harm (Higbee et al., 2022). Many pro-conversion therapy studies and research utilize biased samples, including clients who have recently undergone such therapies, distorted the statistics and failed to analyze whether conversion therapy remains effective in the long term. Even then, such studies only show a 30% success rate (Higbee et al., 2022). Through

the lens of queer theory, the debate whether conversion therapy is effective is insignificant because the existence of conversion therapy is rooted in religious homophobia, transphobia and cisheteropatriatchy.

Harmful Effects and Ethical Issues Related to Sexual Orientation Change Efforts

Sexual orientation change efforts (SOCE) are practices intended to eliminate same-sex attraction. SOCE are usually based on the inaccurate belief that sexual attraction towards the same sex is not inborn, but instead, develop in response to pathological, relational, or environmental experiences, and therefore can, or should be altered (Przeworski, et al., 2020). These practices include various approaches that have been practiced, including Christian, psychoanalytic, cognitive-behavioral, psychodynamic, and integrationist approaches. While SOCE-oriented therapies, such as those listed, and therapists violate the American Psychological Association's ethical guidelines for working with LGBTQ+ members, affirming therapists are efficacious and consistent with the same guidelines.

Psychoanalytic and psychodynamic approaches to SOCE are based on the idea that poor parental relationships can prevent an individual from progressing through a "typical" psychosexual development – which can often lead to same sex attraction. Therapies attached to this often consist of hypnosis and psychoanalytic techniques. While studied, the idea that same sex attraction results from familial dysfunction or childhood trauma have been discredited, as there is a lack of evidence and data to support this theory altered (Przeworski, et al., 2020). On the other hand, cognitive-behavioral SOCE are based on the perspective that sexual orientation can be alerted by overcoming cognitive barriers to heterosexuality. Methods include masturbatory reconditioning and aversion therapy, in which a negative response to same-sex

attraction is conditioned by an electric shock when shown pictures or videos of same-sex couples. These methods are now deemed unethical and inhumane.

Other forms of SOCE include, but are not limited to, abstinence training and teaching traditional gender roles, biological methods such as electroconvulsive therapy, surgeries such as lobotomy, castration or removal of ovaries, or hormone therapy. These have all been used historically but are also considered unethical and are currently infrequently used (Przeworski, et al., 2020). Finally, religious methods of SOCE are among the most prevalent methods still used today. Examples of such involve prayer, scripture study, relying on God to change one's sexual identity or orientation, and threats of damnation (Przeworski, et al., 2020).

Existing data proves that SOCE are not efficacious in altering sexual orientation, while studies saying otherwise usually include biased information and data, weakening the validity of the results and study (Przeworski, et al., 2020). As mentioned, many of the methods used historically are considered unethical, harmful, and inhumane. Negative outcomes associated with SOCE, making those harmful, are as follows: depression, relationship dysfunction, anxiety, and increased homonegativity.

Affirmative Therapy for LGBTQ+ Clients

Affirmative therapies are psychotherapy treatment modalities which seek to depathologize LGBTQ+ identities. It is used to validate and advocate the needs of sexual and gender minority clients (Hinrichs et al., 2017). Mental health clinicians may use affirmative therapy techniques to help an LGBTQ+ client foster a more positive conceptualization of their self-identity. During this treatment, a therapist would actively help their client to recognize the dangers of heterosexism, and above all else, be unequivocally supportive of their client's sexual identity and related experience (Medley, 2021). Like humanistic approaches to psychotherapy,

affirmative therapy techniques are best used in tandem with other psychotherapy modalities. For example, some research suggests that combining affirmative therapy techniques with attachment-based therapy techniques for an LGBTQ+ client could help them improve their view of their self while also improving their relationships with the people around them.

Many may argue that affirmation begins before a therapist meets their client. This may be via intake forms that don't assume heterosexuality, or ask for preferred pronouns, posting of a nondiscrimination policy on one's website, or simply by having a rainbow flag in a waiting room. Behaviors such as these communicate to a client that they are accepted and will be provided affirmative care (Hinrichs et al., 2017). As mentioned in the American Psychological Association (APA) guideline, it is important to consider how cultural and contextual factors intersect with sexual orientation and gender identity when providing healthcare to LGBTQ+ individuals (American Psychiatric Association, 2013). Affirmative psychotherapy also requires the therapist to know about and assess personal attitudes toward issues of sexual orientation or gender identity.

Health care providers are encouraged to consider the diverse identities and backgrounds of their LGBTQ+ identifying clients to provide said affirmative treatment. While providers working in metropolitan areas may have more resources and funding compared to those working in rural settings, it is imperative for them to have knowledge on programs offered in other local communities. If none are offered in proximity, they are also encouraged to seek out guidance from nationwide programs that can assist with identifying LGBT-inclusive services (Hinrichs et al., 2017).

Existential Therapy as a Cure for Loneliness Among LGBTQ+ Patients

A major issue faced by mankind that has served as a struggle throughout history is loneliness. Especially concerning LGBTQ+ individuals, a failure to connect with others within inner or outside communities can have disastrous consequences. The symptoms are greater for those who experience marginalization, discrimination, and alienation in society, leading to detrimental outcomes such as: substance abuse, HIV, and suicide (Ratanashevorn et al., 2021). It is not easy for LGBTQ+ identifying individuals to find others who fit with their version of what existential isolation or those who share similar communities in heteronormative societies. Not being able to connect with others on experiences shared by the more dominant culture and traditions is just one of the various factors affecting LGBTQ+ individuals. Another factor that plays a role in feeling isolated from others is one's need to force conceal their sexual or gender identity for safety and acceptance from others. Lack of family support also leads to more loneliness among LGBTQ+ youth. All in all, LGBTQ+ individuals are most vulnerable to feeling existential isolation because it's more challenging for them to alleviate the pain that comes with isolation (Ratanashevorn et al., 2021).

Isolation and loneliness serving as a central concern, this makes existential therapy a compatible approach for addressing issues among individuals in the LGBTQ+ community. Based on the principles of existentialism, this theoretical approach allows existential therapists to address these issues in LGBTQ+ clients. Existential psychotherapy is a dynamic therapeutic approach that focuses on concerns that tend to be rooted in the individual's existence (Ratanashevorn et al., 2021). This type of therapy mainly investigates ways to move past surface everyday concerns and explores existential situations. By uncovering issues related to their ultimate concerns, assisting these clients by confronting existential givens, the therapist can possibly alleviate a client's pain.

It is important to emphasis that said approaches can be tailored to a LGBTQ+ individual's personal experience, best fitting with their identities and culture. Existential therapists hold a phenomenological stance, allowing the affirmation of the client's lived sexual and gender experiences on both the essentialist and constructionist aspects of sexuality (Ratanashevorn et al., 2021). Conclusively, the therapists are tasked with having a therapeutic and affirmative viewpoint towards LGBTQ+ identifying individuals. Because of this viewpoint, a solid foundation to work meaningfully with these individuals is created, assisting in tackling issues such as loneliness and isolation.

The therapist providing the existential therapy to their client has the duty of providing a safe and affirming environment and relationship to counter their sense of isolation (Ratanashevorn et al., 2021). When the client has the desire to alleviate isolation, entering their therapeutic relationship, the therapist automatically becomes their companion to heal said isolation. The emphasis of this type of therapist is to build a genuine relationship and alliance between the therapist and client, neutrally validating the client's lived experience (Ratanashevorn et al., 2021). Meaning, the formed therapeutic relationship created early in the treatment is necessary for clients to form meaningful relationships in the following phases of their treatment.

Benefits of Telepsychiatry

Across the USA, there has been an increase in mental illness issues and those experiencing such symptoms. Patients continue to encounter many barriers to accessing health care, only 43% receiving treatment, such as individual or group therapies (Whaibeh et al., 2019). This serves as a large challenge for underserved LGBTQ+ individuals who experience a higher rate of mental health conditions, with a higher suicidality. These individuals face specific barriers at a clinician, individual, and systemic level.

The state of LGBTQ+ mental health is most challenged, as they are underserved and often, a poorly served population in health care settings. LGBTQ+ identifying individuals face discrimination from select providers and prejudice from medical institutions, causing an increase in mental health needs linked to depression, anxiety, and substance abuse (Whaibeh et al., 2019). Additionally, those living in more rural areas, facing geographic isolation face higher barriers when accessing mental health services in an already limited pool of mental health providers in the area. While approaches are urgently needed to overcome said barriers, telepsychiatry serves as a step in the right direction, allowing clients to gain access to the help and assistance they need.

Another barrier that LGBTQ+ individuals face is the shortage of culturally competent clinicians (Whaibeh et al., 2019). Culturally competent healthcare providers are those able to understand the cultural influences necessary to guide the treatment of patients belonging to a specific community. In the context of LGBTQ+ clients, this entails sensitivity and knowledge on understanding issues faced by LGBTQ+ communities. By doing so, these mental health providers can become self-aware of biases and assumptions made about their client. Having a shortage of culturally competent healthcare providers stems from the lack of education and training provided, making them incompetent to approach care with LGBTQ+ clients. Even though psychologists and psychiatrists in the United States carry positive attitudes towards LGBTQ+ identifying clients, they still do not acquire the level of training, experience, or knowledge to provide for their needs (Whaibeh et al., 2019).

Fortunately, telepsychiatry has emerged as an approach to possibly help overcome these barriers faced by individuals. Also known as telemental health, telepsychiatry is the use of communicative technology to deliver psychiatric (and other) services remotely. As of recently,

telepsychiatry has emerged as an interprofessional field with a community of primary care physicians, nurse practitioners, psychologists, social workers, and nurse's (Whaibeh et al., 2019). Potential clients and patients can choose providers based on profiles, experience, and sometimes past client reviews on websites and phone applications. Not only that, telepsychiatry is a more convenient and cost-effective alternative for in-person psychiatry services, serving as a time saver while eliminating travel expenses and less time away from work (Whaibeh et al., 2019).

Conclusion

For years, society discriminated and oppressed those with varying sexual and gender identities while practitioners spent their ways trying to convert them to heterosexual for their research. Even after the American Psychiatric Association code was modified to acknowledge the variety of sexual identities as normal, deeming conversion therapy as unethical, LGBTQ+ individuals are still reporting high numbers of unsupportive therapy, having less access to competent professionals in the field. With the shortage of culturally competent providers with the proper training needed to provide psychiatry help to LGBTQ+ clientele facing sexual and gender identity issues, the pool of providers isn't as endless as it is for heterosexual clients. Fortunately, being past the time where conversion and other sexual orientation change efforts (SOCE) stood as the only therapies available for LGBTQ+ individuals, there are now various therapeutic options to alleviate feelings of isolation, body dysphoria, and other mental health issues faced. Psychotherapy treatment's such as existential, affirmative, and psychotherapy are just a few to name.

All in all, research and alternative therapies should be improved upon by competent professionals best suited to understand the intersectionality of minority groups and psychology. By adopting gay affirmative attitudes and being active within LGBTQ+ communities, avoiding

heterosexism languages, respect can be shown in various ways. Respect for LGBTQ+ individuals and the mental health issues they face make for greater application in research and future therapeutic studies, forming a deeper understanding of all human experiences and emotions (Vicknair, 2015).

LGBTQ+ Populations Access to Mental Health Resources

LGBTQ+ (Lesbian, gay, bisexual, transgender, etc.) individuals are often stigmatized and discriminated against in various settings. This population is expected to experience inferior mental health outcomes compared to cis-gendered and heterosexual people, a phenomenon healthcare providers need to take note of and act on (Moagi et al., 2021). Facing such barriers, they're at higher risk for substance use, bullying, depression, and other mental health issues compared to the general population. Due to the lack of healthcare providers' awareness, stigmatization, and insensitivity to the unique needs of this community, LGBTQ+ individuals experience significant health inequities with well-documented negative health impacts (Hafeez et al., 2017). The community faces many issues on a clinical and personal level. All in all, there are many ways to address such issues, especially when coming to mental health complications.

Problems

LGBTQ+ individuals, on average, experience a myriad of mental health disparities as well as an amplified risk of suicide compared to cisgender/heterosexual individuals (Madireddy and Madireddy, 2022). There are several explanations for this overrepresentation of mental illness in the LGBTQ+ population backing this statement. For one, LGBTQ+ individuals are often scrutinized and stigmatized by family, peers, and healthcare providers. Those who experience internalized stigma may feel as though they do not deserve respect from healthcare providers or, the same access to healthcare as their heterosexual peers (Moagi et al., 2021). As a result, they may not disclose relevant information to their providers, or avoid seeking treatment overall! These individuals find it troubling to share their sexual orientation or gender identities with providers who may be inept at understanding the experiences and challenges of their (LGBTQ+) community. Given the frequency of said experiences in a negative light in various

settings, in both overt and coverts forms of discrimination, many find the decision as feeling like a “risk” (Henriquez and Ahmad, 2021). Furthermore, stereotypes attached to LGBTQ+ identifying individuals within the healthcare services lead to fear of communicating with providers about mental health hardships, delaying such services that they may need (Moagi et al., 2021). These factors alone may inhibit the access to structural, interpersonal, and psychological resources.

Despite the push we see today for widespread acceptance of LGBTQ+ identities, there is still an abundance of homophobia and transphobia ingrained into our society, causing mental health issues to the population. As such, many LGBTQ+ have likely been exposed to a significant amount of discrimination throughout their lives for their identities, on social media, at school, or by immediate friends and family. Such discriminatory remarks made against them often leads to diminished self-esteem, depression, anxiety, shame, and other negative feelings surrounding their gender identity/sexual orientation. An emphasis on addressing the broad health, mental wellbeing and needs of LGBTQ+ is needed, rather than exclusively using an illness-based focus such as AIDS or HIV. Meaning, we see studies and research done by the CDC (The Center for Disease Control) and other physicians about how much of the homosexual identifying population carries HIV or AIDS, but not enough research including other identities within the LGBTQ+ community (Hafeez et al., 2017). Even then, LGBTQ+ individuals find it difficult to report their sexual identities to their clinicians, some of those clinicians not well trained in addressing such (Hafeez et al., 2017). This lack of communication is responsible for the poor therapeutic alliance, lack of related education, inadequate screenings, and interventions for physical and mental illnesses.

Solutions

Stakeholders and contributors in the community need to assist in developing a cohesive plan to deal with the challenges faced by LGBTQ+ individuals. Policy makers can engage key stakeholders in formulating social and news media campaigns to address these social inequalities and lack of effective and inclusive health care through such messages (Hafeez et al., 2017). Parents, teachers, medical professionals, and peers can also enhance the experience of LGBTQ+ identifying individuals. Parents and youth especially should be at the front and center of these interventions, speaking on their personal experiences whether it is their identity, their child's identity, or another family members identity.

Physicians and mental health professionals should be culturally sensitive to meet the basic needs of the LGBTQ+ population. They should be trained and educated to provide nurturing, open communication, and empathetic care to this population, in a respectful manner (Hafeez et al., 2017). Inservice training using reflective techniques may assist in facilitating mental healthcare providers' awareness of their own stereotypes and beliefs that may hinder management in management of LGBTQ+ individuals. Additionally, such professionals need to address the concerns of LGBTQ+ individuals in their research, taking physical and mental well-being, social welfare into account.

Regarding pediatricians, the most important element of their primary care includes assessing and supporting youth's mental health. This element plays a significant role in LGBTQ+ youth and young adults, who are prone to experiencing stressors associated with family rejection, self-nonacceptance, and stigmatization (Madireddy and Madireddy, 2022). Therefore, pediatricians must be aware of how to apply principles of mental health practice to LGBTQ+ youth as well as have resources available as needed.

Suggested by LGBTQ+ identifying individuals to improve their access to mental healthcare services, they wished for a "responsive, seamless, and holistic services," while being treated with dignity and respect (Moagi et al., 2021). LGBTQ+ individuals also described the importance of building queer-friendly health and community services, including supportive and inclusive, safe spaces in their community (Henriquez and Ahmad, 2021). Lastly, they request that mental health practitioners provide psychoeducation at their workplaces and for significant others (Moagi et al., 2021). A concern voiced by transgender individuals is the refusal of care by healthcare providers due to "lack of knowledge." By this, some providers decline prescribing or treating transgender patients due to uncertainty of how hormones might "intersect/affect" care (Henriquez and Ahmad, 2021). An FTM (female to male) participant apart of Henriquez and Ahmad's study voiced that he understood the reasoning to a certain degree but emphasized that these providers were unwilling to get the training needed to treat patients such as himself. Other participants spoke on the same solution, talking about how these medical professionals should go through training necessary to treat them, noting that there are websites dedicated to showing providers how "easy" it is to prescribe transgender identifying individuals (Henriquez and Ahmad, 2021). Lesbian, gay, bisexual. and queer individuals agreed with this, demanding a good practice guideline be put in place, while requiring additional training for mental health practitioners on LGBTQ+ issues and terms (Moagi et al., 2021).

Conclusion

All in all, healthcare and mental health resources are both lacking for LGBTQ+ populations. Either because said treatment isn't offered, or select professionals do not have the proper training, it makes it difficult for LGBTQ+ individuals to receive the proper care. The lack of resources leading to horrible outcomes such as suicide and deteriorating physical and mental

health, should be a wakeup call for politicians and current and future medical professionals everywhere. By receiving a further education in treating a minority group such as the LGBTQ+ population, this can lead to bettered health outcomes for said individuals.

Chapter 4 redacted to remove personal reflections and any identifying information.

References

Abumrad, J. (Host). (2018, November 16). *Dr. Davison and the gay cure* (No. 3) [Audio Podcast Episode]. In Unerased Podcast. Focus Features. https://www.focusfeatures.com/podcast/unerased

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.).

American Psychiatric Association. (1973). *Diagnostic and statistical manual of mental disorders* (2nd ed. revised).

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.).

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. revised).

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (4th ed.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Anteby, M., & Anderson, C. (2014). The shifting landscape of LGBT organizational research. *Research in Organizational Behavior*, *34*(0191-3085), 3–25. https://doi.org/10.1016/j.riob.2014.08.001

Belluz, J. (2019, January 15). *DNA scientist James Watson has a remarkably long history of sexist, racist public comments*. Vox. https://www.vox.com/2019/1/15/18182530/james-watson-racist

Caruso, G. (Director). (2022). *Conversion* (Documentary). Gravitas Ventures.

Davison, G. C. (2001). Conceptual and ethical issues in therapy for the psychological problems of gay men, lesbians, and bisexuals. *Journal of Clinical Psychology*, *57*(5), 695–704. https://doi.org/10.1002/jclp.1038

De Block, A., & Adriaens, P. R. (2013). Pathologizing Sexual Deviance: A History. *Journal of Sex Research*, *50*(3–4), 276–298. https://doi.org/10.1080/00224499.2012.738259

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, *5*(4), 565–575. https://doi.org/10.3390/bs5040565

Hafeez, H., Zeshan, M., Tahir, M. A., Jahan, N., & Naveed, S. (2017). Health care disparities among lesbian, gay, bisexual, and transgender youth: A literature review. *Cureus*, *9*(4). https://doi.org/10.7759/cureus.1184

Henriquez, N. R., & Ahmad, N. (2021). "The message is you don't exist": Exploring lived experiences of rural lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) people utilizing health care services. *SAGE Open Nursing*, *7*, 237796082110511. https://doi.org/10.1177/23779608211051174

Higbee, M., Wright, E., & Roemerman, R. (2020). Conversion therapy in the southern united states: Prevalence and experiences of the survivors. *Journal of Homosexuality*, *69*(4), 1–20. https://doi.org/10.1080/00918369.2020.1840213

Hinrichs, K. L. M., & Donaldson, W. (2017). Recommendations for use of affirmative psychotherapy with lgbt older adults. *Journal of Clinical Psychology*, *73*(8), 945–953. https://doi.org/10.1002/jclp.22505

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques*, *21*(1), 18–31. https://doi.org/10.1080/08853126.1957.10380742

Kinsey, A. C., Folsom, J. K., Pomeroy, W. B., & Martin, C. E. (1948). Sexual behavior in the human male. *American Sociological Review*, *13*(2), 224. https://doi.org/10.2307/2087036

Medley, B. (2018). Recovering the true self: Affirmative therapy, attachment, and AEDP in psychotherapy with gay men. *Journal of Psychotherapy Integration*, *31*(4). 383–402. https://doi.org/10.1037/int0000132

Madireddy, S., & Madireddy, S. (2022). Supportive model for the improvement of mental health and prevention of suicide among LGBTQ+ youth. *International Journal of Adolescence and Youth*, *27*(1), 85–101. https://doi.org/10.1080/02673843.2022.2025872

Mestel, R. (2004, November 15). *The Kinsey effect*. Los Angeles Times. https://www.latimes.com/archives/la-xpm-2004-nov-15-he-kinsey15-story.html

Milar, K. (2011, February). *The myth buster*. Apa.org; American Psychological Association. https://www.apa.org/monitor/2011/02/myth-buster

Moagi, M. M., Der Wath, A. E. van, Jiyane, P. M., & Rikhotso, R. S. (2021). Mental health challenges of lesbian, gay, bisexual and transgender people: An integrated literature review. *Health SA Gesondheid*, *26*(1487). https://doi.org/10.4102/hsag.v26i0.1487

Mule, N. J., Ross, L. E., Deeprose, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT+ health and wellbeing through inclusive policy development. *International Journal for Equity in Health*, *8*(1), 18. https://doi.org/10.1186/1475-9276-8-18

New York State Department of Health. (2022). *Sexual orientation and gender identity: demographics and health indicators introduction and key findings*. https://www.health.ny.gov/statistics/brfss/reports/docs/2022-16_brfss_sogi.pdf

Nicolosi , L. (2000). *Reflections on the human potential movement*. Catholic Education Resource Center. https://www.catholiceducation.org/en/uncategorized-articles/reflections-on-the-human-potential-movement.html

Przeworski, A., Peterson, E., & Piedra, A. (2020). A systematic review of the efficacy, harmful effects, and ethical issues related to sexual orientation change efforts. *Clinical Psychology: Science and Practice*, *28*(1), 81–100. https://doi.org/10.1111/cpsp.12377

Ratanashevorn, R., & Brown, E. C. (2021). "Alone in the rain(bow)": Existential therapy for loneliness in LGBTQ + clients. *Journal of LGBTQ Issues in Counseling*, *15*(1), 110–127. https://doi.org/10.1080/15538605.2021.1868375

Vicknair, S. (2015). A literature review of mental health professionals work within lgbt populations. *The Rehabilitation Professional*, *23,* 59–68. https://www.researchgate.net/publication/275021123_A_Literature_Review_of_Mental_Health_Professionals_Work_Within_LGBT_Populations

Whaibeh, E., Mahmoud, H., & Vogt, E. L. (2019). Reducing the treatment gap for lgbt mental health needs: The potential of telepsychiatry. *The Journal of Behavioral Health Services & Research*, *47*(3), 424–431. https://doi.org/10.1007/s11414-019-09677-1

Woods, G. (1999). Social Perspectives in Lesbian and Gay Studies: A Reader edited by Peter M. Nardi and Beth E. Schneider. *Body &Amp; Society*, *5*(1), 119—121 https://doi.org/10.1177/1357034x99005001009