Clinical Psychology, Psychiatry and Homosexuality

Frank Muscarella, Barry University, Miami Shores, FL, USA

Abstract

The modern concept of homosexuality as a sexual orientation emerged with the field of descriptive psychiatry in Europe in the late 1800s. It was formally classified as a mental disorder in 1886 with its inclusion in *Psychopathia Sexualis*. Pressure from new research on homosexuality, public advocacy, and criticism of the earlier versions of the psychiatric diagnostic system resulted in its declassification in 1973. Major areas of current research in homosexuality include sexual orientation change efforts, the prevalence of depression and anxiety in homosexual men and women secondary to social stigma and prejudice, and theories on the etiology of homosexuality.

Introduction

The term homosexuality refers to a specific sexual orientation and is the integrated sexual, emotional, and psychological attraction to individuals of the same sex (Ellis and Mitchell, 2000). Today, homosexuality per se is not categorized as a mental disorder in the major psychiatric diagnostic classification systems that are used for the majority of the world's population: the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (5th ed.) (*DSM-5*) (APA, 2013); the 2010 version of the World Health Organization's (WHO) *International Classification of Diseases* (ICD-10) (WHO, 2010); and the Chinese Classification of Mental Disorders (3rd ed.) (CCMD-3) (Lee, 2001; Wu, 2003). Rather, in Western culture, homosexuality is considered a normal variation in human sexuality (Drescher, 2010; Lee, 2001). However, homosexuality has been categorized as a mental disorder in the recent past, and presently across the world it is viewed with varying levels of intolerance that too often leads to harassment and persecution (Hadler, 2012; Reading and Rubin, 2011). Despite the fact that homosexuality has been declassified as a mental disorder, current psychotherapeutic approaches designed to change homosexual orientation to heterosexual orientation are based on the assumption that homosexual orientation is pathological (Drescher, 1998; Flentje et al., 2013; Gonsiorek, 2004; Grace, 2008).

Disagreement about the conceptualization of homosexuality as inherently pathological has existed since homosexuality first came under the scrutiny of the emerging field of descriptive psychiatry in Europe in the mid-1800s (De Block and Adriaens, 2013). Critics of the psychiatric diagnostic system argue that it too often serves as a culturally approved method to pathologize, control, and sometimes punish (cf Silverstein, 2008) socially unacceptable behavior that is more accurately described as nonconforming rather than pathological (Conrad and Angell, 2004). As such, the determination of pathology has been interpreted as partly a political process which, throughout the history of the development of the European and American psychiatric diagnostic frameworks, has resulted in socially unacceptable sexual behavior being consistently labeled as pathological and targeted for treatment and cure (De Block and Adriaens, 2013; Silverstein, 2008). There is no better example of this pathologizing and political process than the history of homosexuality in European and American psychiatry, the outcomes of which were ultimately exported to the world through readily adopted diagnostic classification systems (e.g., Lee, 2001; Mendelson, 2003).

Early History

Homosexual expression has been documented in cultures across the world and across recorded history; and cultural beliefs about it and responses to it have ranged dramatically from negative to positive (Crompton, 2003; Greenberg, 1988). Specifically, the conceptualization of homosexuality in Western culture has changed radically across historical periods. Ancient Greek and Roman cultures are considered the foundation of Western civilization. Homosexual behavior was common among and appreciated by the Ancient Greeks and Romans, and even their Gods engaged in homosexual behavior (Boswell, 1980, 1994; Cantarella, 1992; Dover, 1978). The consensus among historians is that the Ancient Greeks and Romans did not define people in terms of their sexual orientation, rather they described people in terms of the roles that they played in sexual interactions and the preferences they had for sexual partners. Social disapproval resulted not from the sex of the partner but from violations in sexual role (Cantarella, 1992; Dover, 1978). The other ancient European lands were made up of numerous cultures and there is very little documented evidence of their attitudes about homosexual expression. It appears from the few, mainly ancient Roman reports (e.g., Boswell, 1994; Tacitus, 2009), that attitudes in those cultures ranged from negative to positive, depending on the culture and the circumstances.

According to Boswell (1980, 1994), the advent of Christianity in Europe initiated a homogenization of societal attitudes, and consequently rules, toward sex. According to natural law, the only sex that was acceptable was between a husband and wife for procreation. Nonprocreative sexual acts were considered particularly sinful, but the Church in practice was relatively tolerant of unacceptable or 'deviant' sexual acts until around the AD 1200s. At that time, due to social change and perceived threats, the Church embraced orthodoxy with a concomitant intolerance and discouragement of nonprocreative sexual behavior, and in particular, homosexual behavior.

Crompton (2003) disagrees with Boswell and argues that from its inception, Christianity, for reasons that remain unclear, was extremely hostile toward homosexuality. The hostility worsened in terms of condemnation, persecution, and punishment with Christianity's development and spread across Europe and the world. Crompton states that Christianity emphasized and magnified the association of the biblical story of the destruction of Sodom with homosexuality. According to Crompton, Christianity's strongly negative conceptualization of homosexuality and the persecution that followed this, arose from the close association of homosexuality with the belief in God's anger against it and resulting disasters. Finally, he argues that this intense hostility manifested itself both in ecclesiastical laws against homosexual conduct and cruel punishments for it. As the ancient European lands developed into the modern European countries, ecclesiastical law and its penalties for homosexual acts were incorporated into civil law with the same strength of negative attitudes and responses and ultimately exported to the United States and across much of the world (e.g., Fradella, 2002).

The Mid-1800s

The definition of sexual deviance, including homosexual conduct, remained in the realm of moral, legal, and theological considerations until the mid-1800s with the advent of descriptive psychiatry (De Block and Adriaens, 2013). In the mid-1800s, across much of Europe, there was very severe criminalization of homosexual conduct, and some psychiatrists and early sexologists saw this as unjust and attempted social action (Conrad and Angell, 2004; De Block and Adriaens, 2013; Drescher, 2010). Critics from both fields found common ground and argued that people who engaged in homosexual conduct did so due to an innate, congenital condition and therefore punishment was not the appropriate social response.

The innate characteristic argument set the stage for the development of the concept of homosexuality as a condition that people could be identified as having. However, there were two different lines of reasoning about the meaning of the innate quality of homosexuality. Sexologists, including some physicians and psychiatrists, argued that not only was homosexuality a congenital condition but as such, it was part of the natural variation in sexuality and not inherently pathological or a social problem. Therefore, they argued that it should be decriminalized (Conrad and Angell, 2004; De Block and Adriaens, 2013; Drescher, 2010; Scasta, 1998). In fact, the modern term 'homosexuality' was coined in 1869 by a Hungarian journalist and social activist, K.M. Kertbeny (born Benkert) as part of his treatise against Paragraph 143, a Prussian law criminalizing homosexual conduct (Conrad and Angell, 2004; Drescher, 2010). Psychiatry, on the other hand, argued that homosexuality was congenital but pathological. Thus, homosexuality became a topic of interest in psychiatry, with the goal of bringing it into the medical realm for the 'humane' purpose of treatment and cure (Conrad and Angell, 2004; De Block and Adriaens, 2013; Drescher, 2010; Scasta, 1998). The psychiatric conceptualization soon dominated, introduced homosexuality into Western psychiatric nosology, and maintained its dominance through most of the twentieth century (Mendelson, 2003).

The Late 1800s

De Block and Adriaens (2013) report that in the mid-1800s both the general public and civil authority quickly turned to psychiatry for guidance in the determination of normal and deviant sexuality. Psychiatry's influence increased significantly by the late 1800s. One of the most influential books in psychiatry related to sexual deviance was first published in 1886 by the forensic psychiatrist Richard Von Krafft-Ebing: *Psychopathia Sexualis*. It contained three major groupings of sexual perversions, one of which included homosexuality. Although Krafft-Ebing used the terminology coined by Kertbeny, he did not adopt his conceptualization of it as normal variation. In fact, homosexuality was described as a degenerative disorder (Drescher, 2010). This initiated the formal psychiatric conceptualization and categorization of homosexuality as a mental disorder, and it remained as such until 1973 when the American Psychiatric Association declassified homosexuality as a mental disorder.

The development of the term 'homosexuality' and psychiatry's interest in it set the stage for a major cultural shift in focus from an act that was considered criminal to a sexual orientation and state of mind considered to be pathological. Boswell states that most historians agree that "…no Western legal or moral tradition – civil or ecclesiastical, European, English, or Anglo-American – has ever attempted to penalize or stigmatize a 'homosexual person' apart from the commission of external acts" (Boswell, 1993: p. 40 cited in Fradella, 2002: p. 280). However, the conceptualization of homosexuality as a mental disorder did contribute to the stigmatization of homosexual people (Silverstein, 2008). The understanding of and response to homosexuality moved across history from the theological to the legal to the psychiatric, but the strongly negative cultural attitudes about homosexuality remained relatively unchanged. This is best illustrated by the fact that although there was a change in the conceptualization of homosexual acts, and ultimately homosexuality, from sin to crime to mental illness, society's responses to homosexual behavior and homosexuality remained punitive and socially and personally destructive for those categorized as homosexual (Berube, 1990; Conrad and Angell, 2004; Crompton, 2003; Scasta, 1998; Silverstein, 2008).

The Early 1900s

Although *Psychopathia Sexualis* and the dominance of psychiatry formalized homosexuality as a mental disorder in the late 1800s, sexologists and social activists continued to press their point that homosexuality was not inherently pathological or a social problem, to smaller audiences. This disagreement about its conceptualization is best illustrated by the opinion of Sigmund Freud himself whose thinking was influenced by the work of sexologists (De Block and Adriaens, 2013). In 1903 the newspaper *Die Zeit* published an interview with Freud in which he stated "I am…of the firm conviction that homosexuals must not be treated as sick people…Homosexual persons are not sick. They also do not belong in a court of law!" (cited in Isay, 1989: p. 3).

De Block and Adriaens (2013) indicate that in the twentieth century in Europe and the United States two voices continued to

speak about homosexuality: psychiatry and sexology. Psychiatry maintained the pathology model. Sexologists, who included anthropologists, biologists, historians, sociologists, and physicians, became stronger and more well-defined in their approach. Sexologists brought to bear cross-species, cross-cultural, and historical research, as well as observations of essentially normal populations. The sexologists argued more forcefully, with new evidence in hand, that deviations from the sexual norm, such as homosexuality, were neither pathological nor dangerous to society, and they promoted social change in attitudes toward homosexuality. Again, their influence is expressed by Freud. In the famous letter to the mother of a homosexual man written in 1935, Freud stated: "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development" (Freud, 1935/1960a: p. 423, cited in De Block and Adriaens, 2013: p. 283).

The Mid-1900s

American Psychoanalytic Influence

The prevailing voice regarding homosexuality remained that of mainstream psychiatry that held to the pathology perspective. This group was largely psychoanalytic and even though Freud himself did not see homosexuality as inherently pathological, after Freud's death in 1938, his followers became increasingly strident in their opinion that it was (Drescher, 1998). They based their study of homosexuality on the patients they saw in their private and institutional clinical practices (De Block and Adriaens, 2013; Silverstein, 2008). By contrast, one of the reasons that dissenting professionals disagreed with the classification of homosexuality as a mental disorder was that they saw people who were homosexual who lived essentially normal, contented lives. They recognized that although there could be psychopathology in homosexuals, a state of homosexuality was not inherently pathological itself. Freud himself had urged mental health professionals to take a wide perspective on homosexuals, specifically those who did not seek treatment: "If we disregard the patients we come across in our medical practice, and cast our eyes round a wider horizon, we shall come in two directions upon facts which make it impossible to regard inversion as a degeneracy:…" (Freud, 1962: p. 5).

However, other social forces appear to have contributed to some psychoanalysts' commitment to the pathological view of homosexuality. Isay (1989) reports that from its inception as a radical movement, psychoanalysis tended to be conservative, but on the topic of homosexuality it was the most conservative of all the mental-health professions. Isay states that although this is not a uniquely American phenomenon, this attitude is the most fixed in the American psychoanalytic tradition for two reasons.

The first reason is that during World War II (WW II), many analysts held important positions in the US military (cf Berube, 1990). Upon their return after the war they assumed positions of leadership in departments of psychiatry. They were very motivated to link psychoanalysis to medicine and to the disease model, to increase the prestige and influence of psychoanalysis and economic benefit to its members. The second reason is that shortly before the outbreak of WW II many European analysts fled to the United States. They were anxious about their professional and economic situation and quickly gravitated toward the movement to link psychoanalysis with medicine and the disease model to give stability and prestige to the profession. The McCarthy era followed WW II in the early 1950s in the United States. The goal of McCarthy and his adherents was to identify and remove from public life and influence communists, homosexuals, and other nonconforming 'enemies' of the United States. Many psychoanalysts, themselves recent arrivals to the United States, felt vulnerable and fearful and again gravitated to established and conforming professional organizations and doctrine (Isay, 1989). Some critics have also suggested that since psychoanalysts argued that the only effective cure for homosexuality was long-term psychoanalysis, the issue of secondary gain in their adherence to the disease model of homosexuality is open to question (e.g., Silverstein, 2008).

The DSM

The American Psychiatric Association, dominated by psychoanalytic psychiatrists, standardized the psychiatric classification system begun by the Army in 1945 (Berube, 1990), with the creation and publication of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The predecessor of the first edition of the *DSM*, the *Statistical Manual*, and the first edition of the *DSM* (1952) were relatively ambiguous about classifying sexual deviations as mental disorders (De Block and Adriaens, 2013). Although the first edition in 1952 said relatively little about homosexuality, it was classified as a 'sociopathic personality disturbance' that was part of a general category of personality disorders (De Block and Adriaens, 2013; Drescher, 2010). Reportedly, it was possible to diagnose even a contented homosexual as a sociopath because sociopathy was interpreted as a type of personality disorder characterized by a lack of distress or anxiety associated with the observed pathological condition (O'Donohue and Casselles, 2005 cited in Grace, 2008).

The DSM-II

De Block and Adriaens (2013) state that the *DSM-II* was an adapted version of the mental health disorder section of the World Health Organization's eighth *International Classification of Diseases* (*ICD-8*) which itself was an attempt to create a common ground for psychiatrists of different nationalities, institutional backgrounds, and theoretical orientations. In the first six printings (May 1968–October 1973) of the *DSM-II*, homosexuality was categorized unambiguously as a mental disorder (De Block and Adriaens, 2013); specifically, it was reclassified as a sexual deviation (Drescher, 2010). De Block and Adriaens (2013) report that this was the logical conclusion of a predominantly psychoanalytic body creating a classification system for mental disorders based on theory and etiology. That is, since the psychoanalytic theory held by this body stipulated that heterosexuality was the norm and that developmental trauma caused deviation from the norm, homosexuality could only be pathological (in contrast to Freud's thinking about the issue). However, it is argued here that the historically long negative religious and social

attitudes about homosexuality (Crompton, 2003) and the historically recent conditions in American psychoanalysis (Isay, 1989; Silverstein, 2008) must have had a combined effect that contributed to the resistance to a paradigm shift in the psychoanalytic profession. In fact, Drescher (1998) reports that post-Freud, psychoanalytic theories couched moral condemnation of homosexuality in scientific and pseudoscientific metaphors.

The Late 1900s

In the early 1970s, in the United States, there were a number of social forces that were developing, converging, and challenging the conceptualization of homosexuality as pathological. The voices of the sexologists and social activists, present since the beginning in the long discussion of homosexuality, became louder and stronger and appear to have made significant inroads into psychiatry. According to De Block and Adriaens (2013), shortly after the publication of the *DSM-II* in 1968, disagreement about the pathological conceptualization of homosexuality as well as other conditions, became more compelling in psychiatry. One factor influencing this disagreement was a new generation of scientifically trained psychiatrists who, seeing the benefits of psychotropic medications, began to question traditional psychoanalytic conceptualizations and wanted diagnostic categories that were data driven. The first two editions of the *DSM* had not included an explicit definition of mental disorder but, reportedly, relied on an implicit definition that included two criteria: distress and disability or functional impairment. However, most homosexuals exhibited neither, and if they did, an increasing number of mental health professionals understood that their problems resulted not from the state of being homosexual but rather from society's response to it. This realization logically led to the need to clarify the difference between socially unacceptable or deviant behavior and truly abnormal or pathological behavior (De Block and Adriaens, 2013).

Results from new research began to challenge the conceptualization of homosexuality as pathological. Kinsey's research published in 1948 and 1953 demonstrated that homosexual behavior was not the same as homosexuality since a large percentage of the population engaged in the behavior, and a larger percentage than believed had predominantly homosexual orientations. Chiang (2008) reports that Kinsey's work had a significant influence on psychiatrists' attitudes about homosexuality. For example, despite the antihomosexual fervor of the 1950s McCarthy era, the Group for the Advancement of Psychiatry, working with governmental agencies on a report about homosexuality, was relatively supportive of homosexuality. According to Chiang (2008), the report began by citing Kinsey's statistics of homosexual behavior in America and concluded that homosexuals functioned very well in civilian life and government settings, without problems; and suggested that investigations should be carried out on a case by case basis taking into account a variety of circumstances. Evelyn Hooker's (1957) ground-breaking study comparing the assessment results of heterosexual and homosexual men initiated an ongoing body of literature showing that there is no difference in psychological adjustment and functioning based on sexual orientation itself (Morin and Rothblum, 1991).

Another factor that contributed to a challenge of the status quo was a direct outcome of WW II (Berube, 1990). In the United States, many homosexual men and women served in the Armed Forces in WW II, and they served valiantly and effectively, often receiving military honors. They were pathologized by the mainstream of the military psychiatrists (mostly psychoanalytic), and some were persecuted and denied veterans' benefits after discharge. Individuals began to fight this discrimination themselves and with advocates in the veterans hospitals, military, and among local political representatives. After WW II there was an increase in the number of clinical psychologists due to the need to treat veterans. Chiang (2008) reports that clinical psychologists were less accepting than psychiatrists of the pathological view of homosexuality. After the war, many homosexual veterans, men and women, also chose to relocate to large urban areas to live their lives more freely rather than to return to small towns and rural areas and conform to local norms. All of this contributed to a change in their images of themselves from being pathological and victims, to being different but normal and political. This change set the stage for the postwar gay rights movement in the United States, which became a visible political force with the Stonewall riots in 1969. The movement was fueled by a younger generation, a cultural zeitgeist of liberation and antiauthority attitudes, and new research on homosexuality. This social movement confronted the establishment in psychiatry and psychology directly and forcefully, with new research and the devastating social and personal impact of the disease model (De Block and Adriaens, 2013; Drescher, 2010; Silverstein, 2008). The movement was particularly hostile and confrontational toward the psychoanalytic establishment because of its continued promulgation of the disease model and because of lingering resentment of its treatment of homosexual men and women in the Armed Services in WW II (Berube, 1990; Silverstein, 2008).

Declassification

In December 1973, after a long, raucous, and contentious battle with gay rights activists and their allies outside and within the discipline, the Board of Trustees of the APA unanimously accepted a proposal to remove homosexuality from the *DSM-II* (De Block and Adriaens, 2013; Drescher, 2010; Silverstein, 2008). Later, in response to protests from a number of leading psychoanalysts, a referendum was held with 58% of the membership of the APA accepting the proposal and 37% voting against (Silverstein, 2008). Homosexuality was eliminated as a mental disorder in the seventh printing (July 1974) of the *DSM-II* (De Block and Adriaens, 2013). The American Psychological Association and the National Association of Social Workers publicly supported the resolution of the American Psychiatric Association shortly after it was passed (Silverstein, 2008).

Critics of the declassification of homosexuality as a mental disorder argued that the decision was largely a political one (De Block and Adriaens, 2013). It is undeniable that cultural, social, and political forces converged and contributed to the process to depathologize homosexuality, just as they did in the process to pathologize it. Within the socio-political context of Europe in 1886, homosexuality was essentially proclaimed a mental disorder by Krafft-Ebing in *Psychopathia Sexualis*. Homosexuality

was declassified as a mental disorder by popular vote within the socio-political context inhabited by the American Psychiatric Association in 1973. Neither process employed rigorous empirically based standards, and both processes were arguably more socio-political than scientific (cf Grace, 2008). The entire pathologizing–depathologizing issue is consistent with Bayer's (1981) interpretation that "The status of homosexuality is a political question, representing a historically rooted, socially determined choice regarding the ends of human sexuality" (cited in Drescher, 1998: p. 5).

Both processes supported the contention of critics that the psychiatric diagnostic system too often served as a vehicle to pathologize socially unacceptable behavior that was arguably not pathological (Conrad and Angell, 2004; Scasta, 1998; Silverstein, 2008). However, this scientifically questionable pathologizing-depathologizing of homosexuality led to three positive outcomes all present in the subsequent version of the *DSM*, the *DSM-III*: the development of a more data-driven diagnostic classification system; a clear distinction between a mental disorder and socially deviant behavior; and, most importantly, an explicit operational definition of the term 'mental disorder' was derived, which noted that subjective distress and functional impairment were essential features of this condition (De Block and Adriaens, 2013). Further, De Block and Adriaens argue that the reconceptualization of homosexuality was an essential component for the development of the definition of mental disorder, and this has reverberated across proposed diagnostic categories through all subsequent versions of the *DSM*.

Although homosexuality per se was deleted from the *DSM-II*, another, related disorder was added under the diagnostic category 'Sexual Deviations'. A reading of the eleventh printing (January 1978) of the *DSM-II* (APA, 1968) describes "Sexual orientation disturbance [Homosexuality]" as follows: "This is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder" (p. 44).

Subsequent Editions of the DSM

The *DSM-III* (APA, 1980) included an explicit conceptualization of a mental disorder. Parenthetically, the relationship between a mental disorder and socially deviant behavior was clarified: ("When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder") (p. 6). This clarification has run through the later editions of the *DSM*. The DSM-5 (APA, 2013) is more explicit: "Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (p. 20).

The *DSM-III* did not include homosexuality as a mental disorder, but it did include a reformatting of the *DSM-II* sexual orientation disturbance with the new diagnostic category of 'Ego-dystonic Homosexuality' listed in a section titled 'Other Psychosexual Disorders'. This comprised people who had little to no heterosexual interest and experienced homosexual arousal that was unwanted and distressing. This diagnostic category appeared to ignore the fact that distress about one's homosexual orientation was the result of social stigmatization, and this caused distress, not homosexuality itself. This diagnostic category was greeted with great disapproval, rarely used, and eliminated in the revision, *DSM-III-R* (APA, 1987) (De Block and Adriaens, 2013; Drescher, 2010; Silverstein, 2008). However, the association between homosexuality and a mental disorder continued to exist, albeit in a very subtle way. The *DSM-III-R* included the diagnostic category 'Sexual Disorder Not Otherwise Specified' listed in a section titled 'Other Sexual Disorders'. This could cover a number of conditions but included the explicit example of persistent distress over sexual orientation. The number of heterosexuals who complained of this appears to have been zero. This category remained in the *DSM-IV* (APA, 1994) and in the *DSM-IV-TM* (APA, 2000) in a section titled 'Sexual and Gender Identity Disorders'. The *DSM-5* (APA, 2013) does not contain the category and distress about sexual orientation is not described. The slow exit of the association of homosexuality with mental disorder appears to have been due to the lingering effects of psychoanalytic interpretations (Conrad and Angell, 2004; De Block and Adriaens, 2013; Drescher, 2010; Mendelson, 2003; Silverstein, 2008).

Under the *DSM-5*, should debilitating distress about sexual orientation occur in an individual, it could be listed under the diagnostic category of 'Unspecified Mental Disorder' which reads as follows: "This category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any mental disorder" (p. 708). In theory, this diagnostic category would allow a clinician to acknowledge a clinically relevant degree of distress and impairment due to one's sexual orientation without any implication that it is the orientation itself that is responsible for the distress. Thus, it appears that the *DSM-5* has completely severed the association between homosexuality and mental disorder, 127 years after its first appearance in *Psychopathia Sexualis*.

Other Psychiatric Classification Systems

The World Health Organization's International Classification of Diseases *ICD-10*, published in 1992, removed the diagnostic category 'homosexuality' (Mendelson, 2003), but added some other categories. The 2010 version of the *ICD-10* (WHO, 2010) has a general category (F66) titled "Psychological and Behavioural Disorders Associataed with Sexual Development and Orientation". It is specified that "Sexual orientation by itself is not to be regarded as a disorder". It then lists the following diagnoses: sexual maturation disorder, egodystonic sexual orientation, sexual relationship disorder, other psychosexual development disorders and psychosexual development disorder, unspecified. 'Sexual maturation disorder' is a term that can be applied to those who experience anxiety or depression because of their gender identity or sexual orientation, and is most applicable to adolescents. Egodystonic sexual orientation is the term for those who are distressed by their gender identity or sexual orientation and want to change it. Sexual relationship disorder is the term for those whose gender identity or sexual

orientation is responsible for difficulties in developing or maintaining a relationship with a sexual partner.

It appears that classification in the *DSM-5* is more evolved than that in the *ICD-10* in several ways: the *DSM* separates sexual orientation from gender identity, and it has done away with explicit diagnostic categorization of distress related to sexual orientation. As has been reviewed, essentially distress occurs only in cases of a homosexual orientation, and it is an accepted fact that this problem results from social stigma, not from the orientation itself. It has been argued that the presentation of sexual orientation in the *ICD-10* should be revised (Mendelson, 2003).

The Chinese Classification of Mental Disorders (3rd ed.) (*CCMD-3*) is used in China, which contains 20% of the world's population. The *CCMD-3*, published in 2001, has been heavily influenced by the *DSM* and the *ICD*, but incorporates elements unique to Chinese culture (Lee, 2001). The third edition dropped the diagnostic category of 'homosexuality' but added 'ego-dystonic homosexuality' (Wu, 2003). More specifically, Lee (2001) reports that despite an understanding that homosexuality is considered a normal variant in the Western world, exclusive homosexuality is considered a mental disorder, but only if it causes distress and a desire to change it. Lee states that it is not clear why heterosexuals who are distressed with their sexual orientation are not considered mentally ill. His interpretation is that the Chinese psychiatric establishment is going through a step-by-step paradigm shift similar to that experienced by the American psychiatric establishment.

Contemporary Issues in Research

The subject of homosexuality generates a considerable amount of research from a variety of perspectives. Three major areas are considered here. These are the outcomes of sexual orientation change efforts, the prevalence and causes of mental illness in homosexual men and women, and theories on the etiology of homosexuality.

Sexual Orientation Change Efforts

Therapies known as conversion therapy, reparative therapy, and sexual reorientation are collectively referred to as sexual orientation change efforts (SOCE). According to Drescher (1998), despite the declassification of homosexuality by the APA in 1973, a small group of conservative psychoanalysts maintained that homosexuality was indeed a pathological condition and a homosexual orientation could be changed to heterosexual orientation. SOCE were linked primarily to psychodynamic and behavioral theories in the 1960s and 1970s (Flentje et al., 2013). SOCE today do not appear to have close association with any psychological theory. However, they do appear to be the direct descendants of earlier psychoanalytic change efforts that have been adopted and modified by some fundamentalist Christian groups (Drescher, 1998). Currently, the change therapies use a group of verbal interventions that essentially discourage homosexuality and encourage heterosexuality (Flentje et al., 2013). Most of the individuals who seek out such treatment are those who are having problems reconciling their fundamentalist Christian faith with their homosexual orientation (Drescher, 1998; Flentje et al., 2013; Gonsiorek, 2004; Grace, 2008). Some of these individuals are minors who have been forced into therapy by their parents.

SOCE have come under scrutiny and criticism. It has been argued that behavioral science and the psychological techniques derived from it are not good to help people reconcile issues of religious doctrine, because of the inherent conflict between faith and science regarding the source of truth (Gonsiorek, 2004; Grace, 2008). Major mental health organizations in the United States including the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers have all made policy statements rejecting SOCE (Flentje et al., 2013; Grace, 2008). Half a century of research on SOCE has not shown that they work. The American Psychological Association has stated that there is no demonstrated evidence that SOCE are effective and there is some evidence that they may cause harm (Hancock et al., 2012). Relying partly on this argument, both the states of California and New Jersey passed laws in 2013 banning the use of SOCE for individuals under the age of 18.

Homosexuality and Mental Illness

Although homosexuality is not a mental disorder, the evidence suggests that homosexual adolescents (Mustanski and Liu, 2013) and men and women (Cochran et al., 2003) may be more vulnerable than their heterosexual counterparts to some forms of mental illness such as anxiety and depression. An enormous body of psychological research, beginning with Evelyn Hooker (1957) and up to the present, has consistently shown that there are no psychological differences between people based on sexual orientation alone; and when differences do occur they are the result of society's response to homosexuality, not of homosexuality itself. Research indicates that differences in psychological functioning that do exist between homosexuals and heterosexuals result from the stress associated with the societal pressures on homosexuals as a marginalized group (Grace, 2008; Meyer, 2013).

Homosexual men and women across the world live under varying levels of social marginalization and intolerance that lead to varying levels of aggression against them (Hadler, 2012; Reading and Rubin, 2011; Meyer, 2013; Sue, 2010). Western countries have the lowest levels of gross aggression toward homosexual men and women and greater tolerance (Hadler, 2012; Reading and Rubin, 2011). However, even in Western countries, homosexual men and women, like individuals of many socially marginalized groups, are more likely to suffer from an accumulation of microaggressions in daily life (Sue, 2010). Microaggressions are verbal, behavioral, and environmental insults that communicate hostility, dislike, and disdain and are detrimental to psychological and physical well-being. Meyer (2013) conducted meta-analyses and found that homosexual men and women have a higher prevalence of mental disorders than do heterosexuals. He attributes this to what is termed 'minority stress' or the stress of living as a minority group suffering from stigma and social prejudice. Stigma and prejudice generate micoaggressions (Sue, 2010). Meyer recommends that interventions at both the personal level (e.g., improving individual coping methods) and the structural level (e.g., changing oppressive social and legal

policies) may be useful in alleviating minority stress. Consistent with Meyer's observation, research has shown that socializing agents such as laws affect the individual's attitudes toward homosexuality with more legal protection of homosexuality contributing to greater acceptance (van den Akker et al., 2013).

Theories on the Etiology of Homosexuality

At this time, it is not scientifically known how a particular sexual orientation develops nor can deviation from heterosexual orientation development be reliably predicted. The consensus among most of the scientific community is that sexual orientation develops in an individual as the result of an interaction between genetic, biological, developmental, psychological, cultural, and unique experiential factors. However, there are a number of theories on the development of homosexual orientation. These share the implicit assumption that sexual orientation development would be expected to be heterosexual or fall on a continuum from heterosexual to bisexual because of the direct relationship of these orientations to reproduction. Because exclusive homosexuality is not directly associated with reproduction, its prevalence has generated interest in its possible origins. Comprehensive reviews and critiques of the theories on the etiology of homosexuality are presented by Rosario and Schrimshaw (2014) and LeVay (2011). Muscarella (2006) presents a review of evolutionary theories. A summary of all of these theories follows.

The theories on the etiology of homosexuality have emerged historically with the predominant scientific paradigms that developed across time and were applied to human sexuality. The major contemporary theories of the etiology of homosexuality begin with Freud in his psychoanalytic theory. He theorized that homosexuality in males was one possible product of an unresolved oedipal complex, in which a boy failed to identify with his father. In the little he wrote about female homosexuality, its origins appear to be due, not to an unresolved Electra complex, but rather to a later turning away from the father because of anger and disappointment. The behavioral theories attribute the development of homosexual orientation to learning and the result of classical and operant conditioning. The advent of research on prenatal hormonal influences on the development of brain organization and sexual behavior in nonhuman animals led to a number of neurohormonal theories. These hold that various factors may disrupt the normal level of prenatal hormones during gestation, resulting in the organization of the brain for homosexual orientation. The "exotic becomes erotic" model by Bem includes both neurohormonal and social factors. Bem theorizes that males and females exhibit sex-typed behavior that makes them different from each other, or exotic; and across development, the exotic becomes sexually attractive or erotic. Prenatal hormonal variation causes some children to develop some gender-nonconforming behavior. Thus, the behavior of their own gender is exotic, and ultimately, they become attracted to members of their own gender.

The identification of genetically linked characteristics generated theories on the possibility of an inherited gene, or set of genes, that resulted in a homosexual orientation.

Since, in theory, these genes could not be passed on directly, other theories were developed to explain a possible process. These theories can be categorized as evolutionary theories because they try to explain how genes associated with a homosexual orientation would have been indirectly reproductively beneficial and thus selected for during human evolution (Muscarella, 2006). The first evolutionary theory was presented by E.O. Wilson who stated that among human ancestors, homosexual men and women may have held particularly high social positions such as the group shaman. This would have raised the status of their families who may have then reproduced more successfully as a result.

Edward Miller theorized that homosexuality is a polygenic trait that results from selection for a number of characteristics that each contribute to fitness. These include tenderness, empathy, and kindness which result from a more feminized brain, which would have made ancestral males more attractive to females as mates and better fathers. In some cases the brain organization is extremely feminized giving rise to a homosexual orientation. Miller uses the maternal immune hypothesis to explain the purported fraternal birth order effect, which holds that the probability of a male developing a homosexual orientation increases with the number of older brothers. The maternal immune hypothesis holds that mothers carry a 'biological memory' (in the form of an H–Y antigen) of the number of sons they have gestated that leads to changes in the intrauterine environment – and results in the feminization of later born males. According to Miller, younger sons, being more sensitive and flexible, would compete less with older brothers for resources. Homosexuality in males would be the rare by-product of genetic variability for the capacity to flexibly exploit various social niches, outweighing the cost of a few individuals who do not reproduce. Another line of research holds that maternally inherited factors are associated with both male homosexuality and increased fecundity in female relatives.

The alliance theory holds that during the course of human evolution, homosexual behavior may have reinforced alliances between same-sex conspecifics, which increased their chances of survival and reproduction (Muscarella, 2006). Thus, there was selection for homosexual behavior in all humans. Genetic variability underlying this behavior may result in individuals with a preference for exclusive homosexual behavior and ultimately the development of a homosexual orientation.

Simon LeVay (2011) looks at biological and psychological data and suggests a compelling neurohormonal theory for the development of homosexual orientation. He argues that homosexuality is a 'package' of mental traits, many of which are gender-atypical, while heterosexuality is a package of mental traits that are gender-typical. He states the association of gendered traits with sexual orientation arises from sexual differentiation of the brain under the influence of sex hormones. LeVay speculates that a number of social and biological factors across human history may have influenced prenatal hormonal conditions and may have influenced the prevalence of homosexuality over time. His theory complements evolutionary theories and could be interpreted as a proximate mechanism for variation in sexual orientation.

Summary and Conclusions

Homosexuality appears to have existed cross-culturally over recorded history. Societies' reactions to homosexuality have

ranged from negative to positive as functions of the historical and cultural traditions of each society. Christianity introduced a very negative view of homosexuality that remained relatively constant across history. With cultural evolution, the conceptualization of homosexuality changed from sin to crime to mental illness. The inclusion of homosexuality in *Psychopathia Sexualis* formally introduced homosexuality to the Western world as a mental disorder, and this conceptualization was then exported across the world and across generations in psychiatric diagnostic classification systems. Disagreement about the inherent pathology and social danger of homosexuality existed from the beginning of the conceptualization of homosexuality. However, it was not until the late twentieth century that research supporting this view was abundant and that Western society was culturally prepared to accept it and act upon it. Although the American Psychiatric Association declassified homosexuality as a mental disorder in the DSM-II in 1973, it is argued here, that it was not until 2013 with the publication of the DSM-5 that the final vestiges of the link between homosexuality and psychopathology finally vanished.

Despite the declassification of homosexuality as a mental disorder in the major psychiatric diagnostic classification systems of the world, some societies and subcultures continue to view it as a mental disorder and support 'treatments' to change it. This is clearly outside of mainstream psychiatry and psychology and more harmful than helpful. Research has also demonstrated that homosexual adolescents, men, and women tend to exhibit more mental disorders such as depression and anxiety as a result of the major and minor psychological stresses associated with stigma, prejudice, harassment, and in some cases persecution. Research shows that psychological interventions at the personal level can help individuals to cope with this minority stress and, consequently, to function more effectively. However, research also shows that interventions at the societal level aimed at changing socializing agents such as law and government policy can lead to more tolerant societies that generate less stress for homosexual men and women. Thus, for the purpose of attaining this goal, efforts to change the socializing agents in societies and subcultures oppressive to homosexual men and women are to be encouraged and supported. Finally, there are numerous theories on the etiology of homosexual orientation. They reflect the predominant paradigms of the times in which they developed. Currently, the neurohormonal and evolutionary theories provide a compelling rationale.

See also: Gender Differences in Personality and Social Behavior; Lesbian, Gay, Bisexual and Trans-sexual Minorities in International Perspective: Overview; Mental Illness, Etiology of.

Bibliography

American Psychiatric Association, 1968. Diagnostic and Statistical Manual of Mental Disorders (second ed., 11th printing, January 1978). American Psychiatric Association, Washington, DC.

American Psychiatric Association, 1980. Diagnostic and Statistical Manual of Mental Disorders, third ed. American Psychiatric Association, Washington, DC.

American Psychiatric Association, 1987. Diagnostic and Statistical Manual of Mental Disorders, third ed., rev. American Psychiatric Association, Washington, DC.

American Psychiatric Association, 1994. Diagnostic and Statistical Manual of Mental Disorders, fourth ed. American Psychiatric Association, Washington, DC.

American Psychiatric Association, 2000. Diagnostic and Statistical Manual of Mental Disorders, fourth ed., text rev. American Psychiatric Association, Washington, DC.

American Psychiatric Association, 2013. Diagnostic and Statistical Manual of Mental Disorders, fifth ed. American Psychiatric Association, Arlington, VA.

van den Akker, H., van der Ploeg, R., Scheepers, P., 2013. Disapproval of homosexuality: comparative research on individual and national determinants of disapproval of homosexuality in 20 European countries. International Journal of Public Opinion Research 25 (1), 64–86.

Berube, A., 1990. Coming Out under Fire: The History of Gay Men and Women in World War Two. Free Press, New York.

Boswell, J., 1980. Christianity, Social Tolerance, and Homosexuality. University of Chicago Press, Chicago.

Boswell, J., 1994. Same-Sex Unions in Premodern Europe. Villard Books, New York.

Cantarella, E., 1992. Bisexuality in the Ancient World. Yale University Press, New Haven.

Chiang, H.H.-H., 2008. Effecting science, affecting medicine: homosexuality, the Kinsey reports, and the contested boundaries of psychopathology in the United States, 1948–1965. Journal of the History of the Behavioral Sciences 44 (4), 300–318.

Cochran, S.D., Sullivan, J.G., Mays, V.M., 2003. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay and bisexual adults in the United States. Journal of Consulting and Clinical Psychology 71 (1), 53–61.

Conrad, P., Angell, A., 2004. Homosexuality and remedicalization. Society 41 (5), 32–39.

Crompton, L., 2003. Homosexuality & Civilization. Belknap Press, Cambridge, MA.

De Block, A., Adriaens, P.R., 2013. Pathologizing sexual deviance: a history. Journal of Sex Research 50 (3–4), 276–298.

Dover, K.J., 1978. Greek Homosexuality. Harvard University Press, Cambridge, MA.

Drescher, J., 1998. I am your handyman: a history of reparative therapies. Journal of Homosexuality 36 (1), 5–24.

Drescher, J., 2010. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. Archives of Sexual Behavior 39, 427–460.

Ellis, A.L., Mitchell, R.W., 2000. Sexual orientation. In: Szuchman, L.T., Muscarella, F. (Eds.), Psychological Perspectives on Human Sexuality. John Wiley & Sons, New York, pp. 196–231.

Flentje, A., Heck, N.C., Cochran, B.N., 2013. Sexual reorientation therapy interventions: perspectives of ex-ex-gay individuals. Journal of Gay & Lesbian Mental Health 17, 256–277.

Fradella, H.F., 2002. Legal, moral, and social reasons for decriminalizing sodomy. Journal of Contemporary Criminal Justice 18 (3), 279–301.

Freud, S., 1962. Three Essays on the Theory of Sexuality (S. James, Trans.). Basic Books, New York.

Gonsiorek, J.C., 2004. Reflections from the conversion therapy battlefield. The Counseling Psychologist 32 (5), 750–759.

Grace, A.P., 2008. The charisma and deception of reparative therapies: when medical science beds religion. Journal of Homosexuality 55 (4), 545–580.

Greenberg, D.F., 1988. The Construction of Homosexuality. University of Chicago Press, Chicago.

Hadler, M., 2012. The influence of world societal forces on social tolerance. A time comparative study of prejudices in 32 countries. The Sociological Quarterly 53, 211–237.

Hancock, K.A., Gock, T.S., Haldeman, D.C., 2012. Science meets practice in determining effectiveness of sexual orientation change efforts. American Psychologist 67 (6), 499–500.

Hooker, E., 1957. Male homosexuality in the Rorschach. Journal of Projective Techniques 22, 957–963.

Isay, R.A., 1989. Being Homosexual: Gay Men and Their Development. Farrar Straus Giroux, New York.

Lee, S., 2001. From diversity to unity: the classification of mental disorders in 21st-century China. Cultural Psychiatry: International Perspectives 24 (3), 421–431.

LeVay, S., 2011. Gay, Straight, and the Reason Why. University Press, Oxford.

Mendelson, G., 2003. Homosexuality and psychiatric nosology. Australian and New Zealand Journal of Psychiatry 37, 678–683.

Meyer, I., 2013. Predjudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychology of Sexual Orientation and Gender Diversity 1 (S), 3–26. Reprinted from: Psychological Bulletin 129(5), pp. 674–697 (2003).

Morin, S.F., Rothblum, E.D., 1991. Removing the stigma: fifteen years of progress. American Psychologist 46 (9), 947–949.

Muscarella, F., 2006. The evolution of male-male sexual behavior in humans: the alliance theory. Journal of Psychology and Human Sexuality 18 (2/3,4), 275–311.

Mustanski, B., Liu, R.T., 2013. A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. Archives of Sexual Behavior 42, 437–448.

Reading, R., Rubin, L.R., 2011. Advocacy and empowerment: group therapy for LGBT asylum seekers. Traumatology 17 (2), 86–98.

Rosario, M., Schrimshaw, E.W., 2014. Theories and etiologies of sexual orientation. In: Tolman, D.L., Diamond, L.M. (Eds.), APA Handbook of Sexuality and Psychology, vol. 1. American Psychological Association, Washington, DC, pp. 555–596.

Scasta, D., 1998. Historical perspectives on homosexuality. Journal of Gay & Lesbian Psychotherapy 2 (4), 3–17.

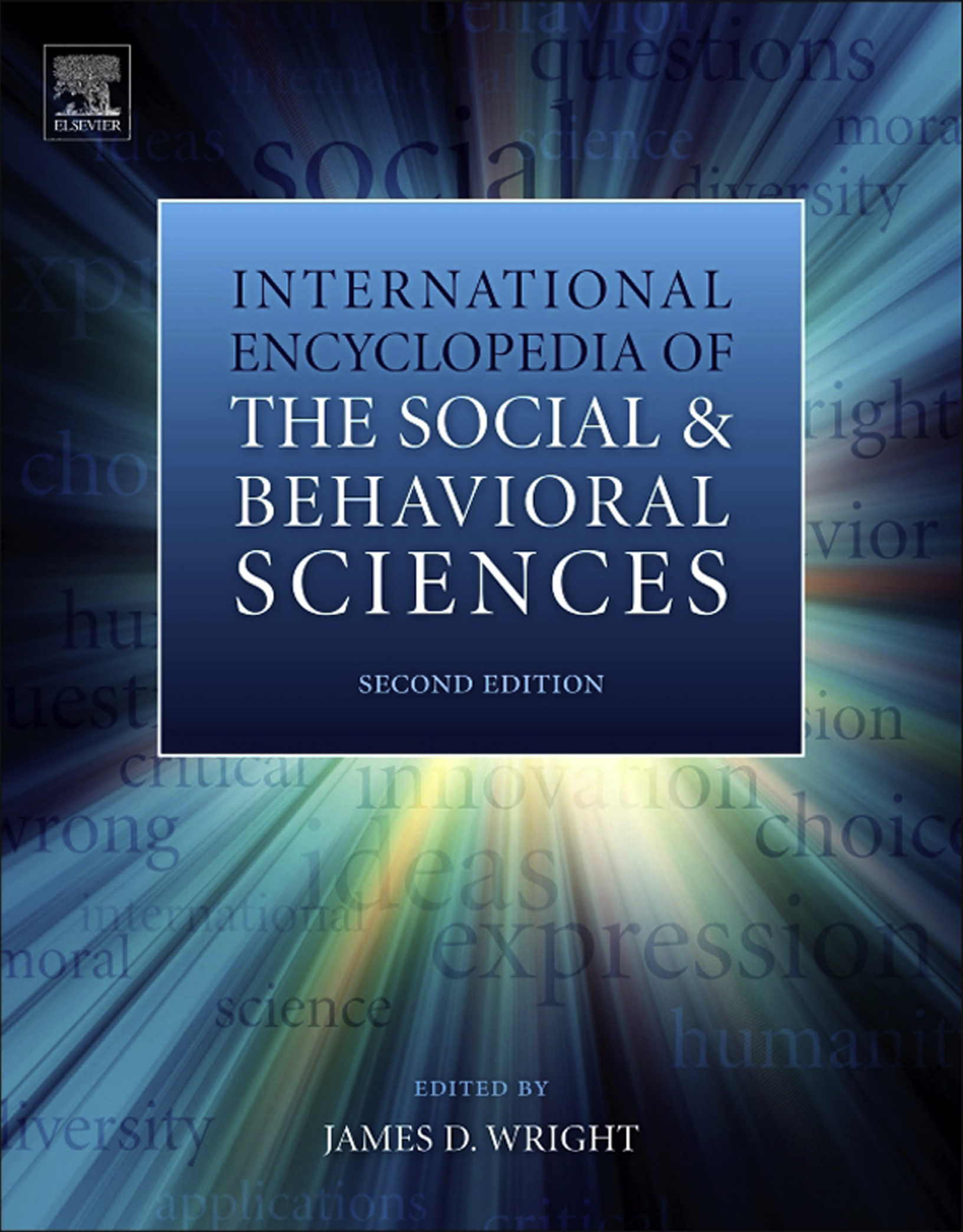
Silverstein, C., 2008. Are you saying homosexuality is normal? Journal of Gay & Lesbian Mental Health 12 (3), 277–287.

Sue, D.W., 2010. Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation. Wiley, Hoboken.

Tacitus, 2009. Agricola and Germany. A new translation by A.R. Birley. Oxford University Press, Oxford.

World Health Organization, 2010. http://apps.who.int/classifications/icd10/browse/2010/en.

Wu, J., 2003. From "*Long Yang*" and "*Dui Shi*" to tongzhi: homosexuality in China. Journal of Gay & Lesbian Psychotherapy 7 (1/2), 117–143.


ELSEVIER
INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL & BEHAVIORAL SCIENCES
SECOND EDITION
EDITED BY
JAMES D. WRIGHT

INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL & BEHAVIORAL SCIENCES

SECOND EDITION

EDITOR-IN-CHIEF

JAMES D. WRIGHT

University of Central Florida, Orlando, FL, USA

VOLUME 1

ELSEVIER

Amsterdam • Boston • Heidelberg • London • New York • Oxford
Paris • San Diego • San Francisco • Singapore • Sydney • Tokyo

Elsevier
Radarweg 29, PO Box 211, 1000 AE Amsterdam, Netherlands
The Boulevard, Langford Lane, Kidlington, Oxford OX5 1GB, UK
225 Wyman Street, Waltham, MA 02451, USA

Notice
No responsibility is assumed by the publisher for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instructions or ideas contained in the material herein, Because of rapid advances in the medical sciences, in particular, independent verification of diagnoses and drug dosages should be made

British Library Cataloguing in Publication Data
A catalog record for this book is available from the British Library

Library of Congress Catalog Number:
A catalog record for this book is available from the Library of Congress

ISBN (print): 978-0-08-097086-8

15 16 17 18 19 10 9 8 7 6 5 4 3 2 1

Publisher: Lisa Tickner
Acquisition Editor: Lisa Tickner
Content Project Managers: Claire Byrne, Michael Nicholls, Gemma Tomalin, Mark Harper
Designer: Maria Ines Cruz

Printed and bound in United States of America