Homosexuality was once considered a psychiatric illness, although that is no longer the case. This is a brief history of how it first came to be classified as a mental disorder and the reasoning and events that led to changes in the way psychiatrists, physicians, scientists and the public now view it.

Until the nineteenth century, official judgments about same-sex behaviors were derived primarily from religious teachings, many of which deemed homosexuality to be “immoral.” Many nations incorporated these religious judgments into their penal codes by criminalizing homosexuality. However, as nineteenth-century western culture shifted power from religious to secular authority, religious views held less sway, and homosexuality received increased attention from the fields of law, medicine, psychiatry, sexology, and human rights activism.

Karl Heinrich Ulrichs, a German trained in law, theology, and history, was an early human rights advocate who in 1864 wrote a series of political tracts criticizing Bavarian laws criminalizing same sex relationships between men (but not women). He argued men born with a woman’s spirit trapped in their bodies constituted a third sex he named *urnings*. He also defined a woman whom we would today call a lesbian as *urningin*, a man’s spirit trapped in the body of a woman. In 1869, Hungarian journalist Károli Mária Kertbeny coined the terms “homosexual” and “homosexuality” in a political treatise against those same laws criminalizing male homosexuality, later codified in 1871 in a newly united Germany’s Paragraph 175. Kertbeny also put forward a theory that homosexuality was inborn and unchangeable.
Ulrichs and Kertbeny proposed early theories of normal variation. These regard homosexuality as a phenomenon that occurs naturally. Such theories typically regard homosexual individuals as born different, but whose differences are natural, like left-handedness. The contemporary belief that people are “born gay” is a normal variation theory. As these theories equate the normal with the natural, they define homosexuality as good (or, at baseline, neutral).

Alternatively, Richard von Krafft-Ebing, a German psychiatrist, had a theory that homosexuality was a “degenerative” disorder. Adopting Kertbeny’s terms, “homosexuality” and “homosexual,” but not his normalizing beliefs, Krafft-Ebing’s 1886 Psychopathia Sexualis viewed all non-procreative sexual behaviors as forms of psychopathology. In an ironic twist of today’s “born gay” theory, Krafft-Ebing believed although one might be born with a homosexual predisposition, such inclinations were a congenital disease. Krafft-Ebing was influential in disseminating among medical and scientific communities both the term “homosexual” as well as its author’s view of homosexuality as a psychiatric disorder.

Krafft-Ebing’s was a theory of pathology, one that regards adult homosexuality as a disease, a condition deviating from “normal,” heterosexual development. In these theories, atypical gender behavior or feelings are symptoms of a “disease.” Adherents to these theories hypothesize that some internal defect or external pathogenic agent causes homosexuality. They believe that such pathogens can occur before birth (intrauterine hormonal exposure) or after (excessive mothering, inadequate or hostile fathering, childhood sexual abuse).

In contrast to Krafft-Ebing, a British sex researcher of the early twentieth century, Havelock Ellis, considered homosexuality a normal variation of sexual expression. So did Magnus Hirschfeld, a German psychiatrist and sex researcher who led the early twentieth-
century homophile (gay rights) movement. Like Ulrichs, he saw homosexuality as normal from a third sex theory perspective.

In contrast to Hirschfeld’s theory of normal variation and Krafft-Ebing’s theory of pathology, Sigmund Freud proposed a third kind of narrative that would also find its way into the popular imagination. According to Freud, since everyone is born with bisexual tendencies, expressions of homosexuality could be thought of as a normal phase of heterosexual development. However, Freud’s belief in bisexuality, which meant there were only two sexes, did not allow for the possible existence of Hirschfeld’s third sex. He wrote in his *Three Essays on the Theory of Sexuality* that he was against any theory that considered “homosexuals” to be a “group of special character.” In the same essay, Freud disagreed with Krafft-Ebing as well: homosexuality was not a “degenerative condition” because, among other reasons, it was found in high functioning, highly intelligent, and highly ethical individuals. Instead, Freud saw expressions of adult homosexual behavior as caused by “arrested” psychosexual development.

What Freud proposed was a theory of immaturity. These theories regard expressions of homosexual feelings or behavior at a young age as a normal step toward adult heterosexuality. Ideally, homosexuality is a passing phase one outgrows. However, as a developmental arrest, adult homosexuality represents stunted psychosexual growth. Those who hold these theories tend to regard immaturity as relatively benign, or at least not as “bad” when compared to theorists of pathology, who often emphasize the potentially malignant meanings of homosexuality.

In support of his theory, Freud wrote several papers attributing the homosexuality of patients and historical figures to family dynamics. For example, in *Leonardo da Vinci and a Memory of His Childhood* (1910), he attributed the artist’s homosexuality to prolonged mothering and an absent father. In his 1920 *Psychogenesis of a Case of Homosexuality in a*
Woman, he argued that a female patient, disappointed by the birth of a younger brother as she entered puberty and was becoming sexually aware, turned away from her father and from men in general. Toward the end of his life, Freud wrote a 1935 Letter to an American Mother responding to her request to change her son’s homosexuality with psychoanalysis. He replied, “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 had pessimistically written in 1920 that, “In general, to undertake to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse, except that for good practical reasons the latter is never attempted.” Yet by the middle third of the twentieth century, Freud’s followers in the next generation mostly regarded homosexuality as an illness. They claimed a new and different understanding of homosexuality that could lead to psychoanalytic “cures” that eluded the field’s founder. They based their views on the theories of Sandor Rado, a Hungarian émigré to the United States whose work had a significant impact on American psychiatric and psychoanalytic thought of the mid-twentieth century. Rado, in contrast to Freud, believed there was no such thing as innate bisexuality or normal homosexuality. Heterosexuality was the only biological norm, and he classified homosexuality as a “phobic” avoidance of the other sex caused by inadequate parenting.

This theory fueled efforts of the next generation of analysts to “cure” homosexuality, much as one treated other forms of neurotic anxiety. Despite their therapeutic optimism, most of their efforts appeared to have been unsuccessful. In a 1962 study, Irving Bieber and colleagues reported treating 106 homosexual men, claiming a 27 percent “cure” rate with psychoanalysis. However, when challenged a decade later to produce a “cured” patient, they were unable to do
so. 1960s practitioners of aversion therapy also claimed “cures.” However, by the 1970s behavioral therapists admitted few of their patients managed to stay “converted” very long.

Psychoanalytic theorists of homosexuality drew conclusions from a biased sample of patients seeking treatment for their homosexuality or other difficulties and then wrote up findings of this self-selected group as case reports. Their theories were also based on studies of prison populations. Sexologists, on the other hand, did field work, recruiting large numbers of non-patient subjects for their studies. In the years when psychiatrists and psychologists were trying to “cure” and change homosexuality, sex researchers of the mid-twentieth century instead studied a wider spectrum of individuals of non-patient populations.

Most prominent among those studies was the research of Alfred Kinsey and his collaborators: *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953). Kinsey surveyed thousands of people and found homosexuality to be common in the general population. Kinsey’s now-famous claim that 10 percent—today believed to be closer to 1–4 percent—of the population engaged in homosexual behavior was at odds with psychiatric claims that homosexuality was extremely rare in the general population. In 1957, Evelyn Hooker, a psychologist, published a study that failed to find greater signs of psychological disturbances in a group of non-patient homosexual men than in non-patient heterosexual controls. However, American psychiatry, influenced at the time by psychoanalysis, mostly ignored this growing body of sex research.

This was the general state of affairs when, in 1952, the American Psychiatric Association (APA) published its first edition of the *Diagnostic and Statistical Manual* (DSM-I), listing all of the conditions psychiatrists then considered to be mental disorders. DSM-I classified
“homosexuality” as a “sociopathic personality disturbance.” In 1968’s DSM-II, homosexuality was classified as a “sexual deviation.”

However, by 1970, the scientific sex research favoring a non-pathological view of homosexuality was dramatically brought to the attention of APA. In the wake of the 1969 Stonewall riots in New York City, a greatly energized national movement of gay and lesbian activists believed one of the biggest obstacles to achieving equality for gay people was the stigmatizing psychiatric diagnosis of homosexuality. This led to their disrupting the 1970 APA meeting in San Francisco.

Their protests succeeded in getting APA’s attention, leading to groundbreaking educational panels at the next two annual meetings. An unprecedented 1971 panel, entitled “Gay is Good,” featured gay activists Frank Kameny and Barbara Gittings explaining to psychiatrists, many hearing this for the first time, the stigma caused by the “homosexuality” diagnosis. Kameny and Gittings returned to speak at APA’s 1972 meeting and wanted a gay psychiatrist to join them. However, finding an openly gay psychiatrist in 1972 was no easy task, as at the time, homosexuality was illegal in most states. A physician could lose his license for admitting engagement in “immoral behavior” that was against the law. He would certainly lose his job and patient referrals. The solution was for John Fryer, MD, to appear in disguise as Dr. Henry Anonymous, a “homosexual psychiatrist.” Given the realistic fear of adverse professional consequences for coming out at that time, Fryer concealed his true identity from the audience, wearing a rubber mask, a fright wig, and an oversized tuxedo and using a voice-disguising microphone to speak of the discrimination gay psychiatrists faced in their own profession.

As protests and panels took place, APA also embarked upon an internal deliberative process about the question of whether homosexuality should remain a psychiatric diagnosis. The
Northern New England Psychiatric Society, under the leadership of Lawrence Hartmann, MD, and Richard Pillard, MD, developed position statements to help guide APA in its decision-making process. The Nomenclature Committee, APA’s scientific body delegated to address this issue, wrestled with the question of what constitutes a mental disorder. This included testimony from individuals like Charles Silverstein, PhD, an early gay rights activist and clinical psychologist, who presented them with sex research they knew nothing about.

Robert Spitzer, MD, who chaired a Nomenclature Subcommittee, was led to ponder the question of what is and what is not a mental disorder. At the time, the DSM had no official definition of what constituted a mental disorder. Spitzer concluded that most mental disorders, with the exception of homosexuality and perhaps some of the other “sexual deviations,” all caused subjective distress or were associated with generalized impairment in social functioning. Having arrived at this novel definition of mental disorder, which would only officially become part of DSM-III in 1980, the committee concurred that homosexuality per se was not one. Several other APA committees and deliberative bodies then reviewed their work and approved that decision. Finally, in December 1973, APA’s Board of Trustees (BOT) voted to remove homosexuality from the DSM.

However, psychiatrists from the psychoanalytic community objected to the decision. They gathered 200 signatures to petition APA to hold a referendum asking the entire membership to vote either in support of or against the BOT decision. APA had 20,000 members at the time, 10,000 of whom voted, with 58 percent voting to uphold the decision. The removal of homosexuality was accompanied by an APA position statement—the first of many APA position statements supporting civil rights protections for gay people. Within two years of the APA’s removal of homosexuality per se as an illness, other major mental health professional
organizations, including the American Psychological Association, the National Association of Social Workers, and the Association for Advancement of Behavior Therapy endorsed the APA decision.

This action did not, however, mean that APA was endorsing a normal variant model of homosexuality. Nor did it immediately end psychiatry’s pathologizing of some presentations of homosexuality. In homosexuality’s place, DSM-II had a new diagnosis, Sexual Orientation Disturbance (SOD), which regarded homosexuality as an illness if an individual with same-sex attractions found them distressing and wanted to change. The new diagnosis served the purpose of legitimizing the practice of sexual conversion therapies (and presumably justified insurance reimbursement for those interventions as well), even if homosexuality per se was no longer considered an illness. The new diagnosis also allowed for the unlikely possibility that a person unhappy about a heterosexual orientation could seek treatment to become gay.

In 1980, DSM-III dropped SOD and substituted it with “Ego Dystonic Homosexuality” (EDH). However, it was obvious to psychiatrists more than a decade after the 1973 decision that the initial inclusion of SOD, and later EDH, was the result of political compromise and that neither diagnosis met the definition of a disorder in the new classification system. Otherwise, all kinds of identity disturbances could be considered psychiatric disorders. “Should people of color unhappy about their race be considered mentally ill?” critics asked. What about short people unhappy about their height? As a result, EDH was removed from DSM-III-R in 1987. In so doing, APA implicitly accepted a normal variant view of homosexuality in a way that had not been possible fourteen years earlier.

The diagnosis of homosexuality would eventually follow a parallel trajectory in another major diagnostic system. In 1992, the World Health Organization (WHO) removed
“homosexuality” from its Tenth Edition of the International Classification of Diseases (ICD-10), replacing it with a diagnosis called Ego-Dystonic Sexual Orientation. Presently, ICD is undergoing a revision process, and ICD-11 is scheduled for publication in 2018. WHO’s Working Group on the Classification of Sexual Disorders and Sexual Health has recommended these categories be deleted entirely from ICD-11.

In retrospect, the gay activists who disrupted APA’s meetings had the right idea about overcoming stigma. Following the 1973 decision, social acceptance of openly gay men and women gradually reached unprecedented levels, in part because religious, government, military, and educational institutes were deprived of a medical or scientific rationalization for discrimination. For example, in 1973, one could prevent “homosexuals” from immigrating to the US because doctors classified them as mentally ill. Once homosexuality was no longer a mental disorder, being gay was no longer was a rationale for exclusion. Nevertheless, change occurs slowly: Immigration and Naturalization Service did not remove that barrier until 1990.

Similarly, it took a long time for the changes effected by APA’s decision to work their way into the wider culture. Eventually, a new cultural perspective emerged: (1) if homosexuality is not an illness, and (2) if one does not literally accept biblical prohibitions against it, and (3) if contemporary, secular democracy separates church and state, and (4) if openly gay people are able and prepared to function as productive citizens, then what is wrong with being gay?

These changes bring us to the present. For if there is nothing wrong with being gay, then what moral and legal principles should the larger society endorse if gay people are to freely and openly live their lives? These are the questions we are openly debating today.
References


