IRP Commission: SEXUAL MINORITIES AND MENTAL HEALTH: Global Perspectives

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Executive Summary

Background: Sexual orientation is a key determinant of the identity of human beings . It has also been seen as a social determinant of health. People whose sexual orientation is non-heterosexual or sexual minorities or sexually diverse are included in the broad umbrella term LGBT (Lesbian, Gay, Bisexual, and Transgender) which is a commonly used acronym in activism, social policy, and subsequently cultural literature.

Aims: For this reason, this Commission focuses primarily on sexual orientation i.e. lesbian, gay and bisexual (LGB) groups. We have used terms non-heterosexual, sexual minorities or sexual variation interchangeably. We have not considered asexual individuals as research in the field is weak. We are cognizant of the fact that topics relating to mental health and sexual orientation discussed in this Commission will intersect with other issues of personal, cultural and social identity, and will thus be relevant to individuals including many transgender individuals. The inclusion of mental health issues relevant to gender-diverse individuals as well as gender identity is important and deserves its own separate detailed discussion.

Findings: The exact number of sexually diverse individuals in a population is often difficult to estimate but is likely to be around 5% of the population. Rates of various psychiatry disorders in LGB populations are higher than general population and these have been attributed to minority stress hypothesis. Elimination of inequality in law can lead to reduction in psychiatric morbidity in these groups. However, these are all diverse groups but even within each group there is diversity and each individual has a distinct and unique experiences, upbringing, responses to their own sexual orientation, and generating varying responses from others (including healthcare professionals).

Recommendations: The mental healthcare needs differ and must be taken into account in healthcare and policy development. Improving access and reducing stigma will help. The

commission recommends that there is no role for so-called conversion therapies and other recommendations are made for clinicians, researchers and policymakers.

Background

Sexuality or the capacity for sexual feelings, forms an integral part of an individual's identity. Sexuality is deemed to have three key components - behaviour, fantasies and innate orientation. Sexual orientation is an innate form of sexuality which affects sexual preferences both in behaviour and fantasy. Sexual behaviour in turn, is dictated by accessibility to sexual partners. Whilst the purpose of sexual behaviour can be recreational or procreative, this is strongly influenced by the attitudes of cultures in which individuals grow up, live, age and play. Broadly, factors such as culture, personal and family identities, religion, societal influences and social expectations all help mould an individual and their personal and sexual identities. Variations from heteronormative sexuality and behaviour historically have often been steeped in pathological terms from a psychiatric perspective. Psychiatric practice perhaps more than other medical practice carries with it bio-psycho-social models of etiology and interventions hence likely to be affected by social attitudes. This is attributable to the role society and social expectations play in the lives and functioning of individuals and pathologisation of certain behaviours be they sexual or otherwise. Cultures define and dictate what is normal and what is seen as deviant. The responses in psychiatry and psychology have always been strongly influenced by social mores and norms as societies define abnormality and thus acceptability of behaviours. Over the past five decades or so in many countries, negative attitudes towards non-heterosexual behaviours have changed as a result of a number of factors including political activism. Such changes in social attitudes to sexual minorities have led to increasing acceptance and 'normalisation' and sexual variations are now generally considered to be

representative of the usual human experience even though in many societies and countries, negative attitudes and consequences continue to persist.

Sexual orientation is increasingly recognized as an important demographic characteristic in health research especially when considering under-privileged populations and social determinants of health. “LGBT” (Lesbian, Gay, Bisexual, and Transgender) is a commonly used acronym in activism, social policy, and subsequently cultural literature, to identify individuals who experience sexual and gender diversity. Increasingly terms such as LGBTQ+ are being employed. Lesbian, gay, bisexual and transgender (LGBT) groups are often lumped together for convenience in research as well as policy However, diversity and heterogeneity of these different groups, each with their distinct and unique experiences, upbringing, responses to their own sexual orientation, gender and sexual identities can lead to varying responses from others (including healthcare professionals). Their healthcare needs remain different and variable and must be taken into account in healthcare and policy development. For this reason, this Commission focusses primarily on sexual orientation i.e. lesbian, gay and bisexual (LGB) groups. The terms often used to describe these three groups are sexual minorities or sexual variation. Although many individuals describe themselves as asexual, this group is not included here for a number of reasons primarily being lack of research and lack of data from nations other than high income countries. For a similar reason individuals who are plurisexual e.g. pansexual or polysexual for the same reasons.

We also recognise that the topics relating to mental health and sexual orientation discussed in this Commission will intersect with other issues of personal, cultural and social identity, and will thus be relevant to individuals including many transgender individuals. The inclusion of mental health issues relevant to gender-diverse individuals as well as gender identity is important but and deserves its own detailed discussion.

Definitions:

The concept of sexual orientation comprises sexual behaviour, sexual attraction, physiological sexual arousal and sexual identity(1). Sexual behaviour describes interactions of a sexual nature between two or more people. Sexual attraction may include an individual’s romantic, sexual or emotional attraction to others, which may include men, women, both or neither gender. Physiological sexual arousal may occur following exposure to erotic stimuli.

“Sexual orientation” and “sexual identity” are often used interchangeably in the literature and popular culture. However, sexual identity refers to a self-ascribed identity or descriptor of sexual orientation, for example heterosexual or “straight”, and homosexual or same-sex attracted. The term “gay” was used more as a political identity in the last century but in recent times, this has changed and has become a commonly used and accepted term for describing male same-sex behaviour and attraction. Same-sex attraction is defined as often, but not always, attraction to others who have the same sex or gender identity as their own. People who have a bisexual identity are attracted to others with genders that are similar or different from their own.

In some settings, the LGB communities see the term “homosexual” as antiquated and offensive and “same-sex attracted” is sometimes the preferred descriptor. The term “queer” was originally seen as offensive but has now been reclaimed by the LGB community and is even used in academia as many universities offer courses on “queer studies”, thus demonstrating how societal attitudes can influence the language related to sexual orientation and how societies deal with these changes and in turn how disciplines such as psychiatry and psychology respond. Consequently , sexual minority status has often been medicalized or psychiatrised by labelling it as a psychiatric diagnosis requiring treatment and often practitioners have gone along with it. Sexual minorities have been recognized for millennia-sometimes more favourably than others and attitudes and responses change in response to changes in society.

In the following section we shall briefly summarise some of the historical accounts. We do not propose this section to be exhaustive and the focus is highlighting societal responses especially as diagnostic features.

Historical Development of Diagnostic Nomenclature:

In Western societies and cultures, same sex behaviour has often been very strongly criticized by many organized religions and faiths. The shift to a more secular system may have contributed to a change in attitudes but this has not been a consistent or smooth change. As psychiatry itself emerged from the influence of religion, many conditions seen previously as pathological became non-pathological while others moved from having a religious interpretation to being considered indicative of insanity.

Karl Maria Benkert, an Austrian-born Hungarian journalist and human rights campaigner, used the term “homosexuality” and “heterosexuality” in an 1868 German pamphlet, as did Richard von Kraft-Ebbing, an Austro-German psychiatrist, in his seminal work, Psychopathia Sexualis in 1888(2). It was around the same period that the term psychiatry itself emerged replacing “alienism” (3) as patients were known as aliens and their treating doctors as alienists. However, the modern definitions of heterosexual and homosexual can be attributed to Freud in his 1905 work, Three Essays on the Theory of Sexuality (4). Focusing on syndromes rather than personal narratives reflects psychiatry’s allegiance to the biomedical model of mental illness (5) thus further contributing to stigma and discrimination due to pathologisation. The relationship between organized religion and psychiatry has often been ambivalent (6) However, it is well recognized that religious thoughts, practice and experiences influence psychopathology and psychiatric practice (7).

It is important to understand the history of clinical psychiatric and various influences which may have contributed to the profession’s attitudes to pathologisation of sexual minorities.

The legacy of the Abrahamic religions (Christianity, Islam, and Judaism) may be seen as leading to “vice-laden concepts” in the practice of psychiatry which refer to wrongful, criminal, or immoral activity(8,9). For example, the Christian capital vices, or sins (such as greed, wrath, or envy), remain inscribed in the description of some personality disorders (8). One would also hardly deny the similarity of the ontological assumptions (i.e., those of the very nature of things) in psychiatric notions of sexuality to those of renowned 13th century Christian theologian Thomas Aquinas’ account of natural law (10). Prior to being taken over by the 19th-century medical professionals, the term “perversion” was used to indicate deviations from a divinely sanctioned norm (11). In both Christian and psychiatric accounts sexual variations have been assumed to be of “natural” and “unnatural” kinds or, rephrased in medical terms—as distinguishable into the “healthy” and the “pathological”. This reflects how a religious notion—with its underlying value judgements—may be the precursor of a psychiatric one. Moral impact of religion and law plays a major role in psychology and psychiatry. This has led to tensions between clinicians and their patients especially related to morality and psychopathology (12). Until the mid-19th century, sexual perversion or deviance, was understood mainly in the theological-judicial terms (11), but was gradually redefined in terms of public health, backed up by the medical rationale. The Christian suspicion of, if not an explicit condemnation of, non-procreative sexual conduct is evident throughout the 18th- and 19th-century medical works, linking masturbation or sex for non-procreative purposes with adverse mental or

somatic consequences (13). These attitudes still persist in many cultures. Consequently male homosexuality in particular was pathologized and criminalised in many countries. It is often mentioned that Queen Victoria did not believe that female same-sex behaviours existed. Thus, it was male same-sex behavior which was often punishable by prison and death. In the past five decades or so there have been significant changes in attitudes and policies in many countries especially in the West although other countries are beginning to change too. The process of decriminalization had started in the late 18th century after the French Revolution, when France adopted a new criminal code based on human and civil rights, abolishing penalties for crimes against morality. Although acceptance of same-sex behaviour may have increased overall, this remains patchy. Over time, acceptance of homosexuality appears to have increased in the most accepting countries but decreased in the least accepting countries (14).

Although not universal, the process of the depsychopathologization of homosexuality has been strongly influenced by LGB activism, attitudes to sexual minorities remain strongly influenced by organized religion in many societies. The Scientific-Humanitarian Committee, founded in 1897 in Berlin - to campaign for social recognition of gay, bisexual and transgender men and women, and against their legal persecution - was the first LGBT rights organization in history (2). The same sex behavior was seen as "demonic" by religious leaders at the time but transmogrified into 'scientific concepts of insanity' (15) and therefore needed to be dealt with at multiple levels. The clinical concepts of sexual variation and sexual diversity were not only strongly influenced by Victorian mores and morals (16, 17), but imposed on parts of the world colonized by the European colonialists especially the British, and these attitudes persist in many of those ex-colonies. This persistent social and legal scenario may well have contributed to the inclusion of same sex behaviour as a diagnosable (and by inference, pathological and treatable) term in the ICD-6 (WHO 1948). Same sex attraction was considered a part of a Pathological Personality, in the sub-category Sexual Deviations. In the Diagnostic and Statistical Manual (DSM), homosexuality was first classified as a "sociopathic personality disturbance"(18). In ICD-8 (WHO 1965) same-sex attraction was transferred to a sub-category entitled "Homosexuality" and was reclassified as a "sexual deviation" in the DSM-II (19). In 1973, following social activism and with influence of some gay psychiatrists, the term "homosexuality" was removed from the DSM II and replaced by Sexual Orientation Disturbance (SOD) (20). One of the main architects of DSM, Robert Spitzer (1981) noted that this change was a compromise between the prevailing ambivalence surrounding same-sex attraction as a mental disorder or "normal sexual variant" (21). He described that SOD included those individuals who

experienced same-sex attraction but were also distressed by it and who wanted to change their sexual orientation. Furthermore, ICD-9 (WHO 1975) retained same-sex attraction in the homosexuality sub-category but in its revisions added a clarification to "classify homosexuality here whether or not it be considered a mental disorder", reflecting not only the diagnostic debate in the scientific and activist communities but also prevalent ambivalence (22). Consequently, in DSM-III (1980) the diagnosis of ego-dystonic homosexuality was introduced. This diagnosis was intended for individuals who experienced distress from their same sex attraction, but the requirement for an individual to want to change their sexual orientation was removed (18). Finally, in DSM-III-R homosexuality as a diagnostic entity was omitted and instead subsumed under Sexual Disorder Not Otherwise Specified to include those individuals who experienced “persistent and marked distress about one’s sexual orientation” (p.296). This continued in the DSM-IV and DSM-IV-TR (23,24). It was eventually omitted in the DSM-5 (24). The landmark decision to remove same-sex experiences from a diagnostic system was thought to reflect the APA’s implicit acceptance that same sex attraction is a variation in the human experience(18). WHO too removed homosexuality from the ICD-10 but not until 1992 and then still included the construct, “ego-dystonic sexual orientation”, which was finally omitted in the ICD-11 in 2019(25). These changes and the journey indicate the role society plays in creating pathologies by defining normal and abnormal behaviours and deviance which psychiatrists and other mental health professionals continue to follow. Hence it is important to be aware of cultural attitudes and norms. In the following section we summarise cultural attitudes and responses to the role and function of sexual activity and sexual identity. We have described cultures in geographical regions but it is critically important to recognize that cultures are heterogenous as well as dynamic and keep evolving and changing and individuals change too.

Role of cultures:

Cultures influence our cognitive and social development and mould our world-view hence it is important to explore and understand cultural influences on our attitudes and behaviours. An attitude is defined as a relatively enduring organisation of beliefs, feelings, and behavioural tendencies towards socially significant objects, groups, events or symbols (26).

Bullough (27) classified cultures into sex-positive (where sexual activity is largely for pleasure) and sex-negative (where cultural activity is purely for procreation) recognizing that cultures have varying attitudes to sexuality and sexual behaviours. He noted that Hindu culture changed from sex-positive to sex-negative under the influence of external forces; invasions and colonisation. Herdt (28) studied

the Sambia tribe in New Guinea and found that teenage boys when reaching puberty were expected to have sex with tribe elders as a rite of passage but these behaviours changed with AIDS breakout. He also noted that many non-Western cultures such as in Thailand and Siberia tend to have less negative (and indeed even positive) attitudes towards same sex experiences. The formation of attitudes is often strongly influenced by historical accounts and the impact of religion on people's daily lives and attitudes. Such contexts are crucial in our understanding of pathologisation of same sex behaviours.

The current state of same sex behaviours around the world is shown in the map.

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December 2020 ILGA World *State Sponsored Homophobia* report - Global Legislation Overview update

A) Asia

The descriptions and attitudes towards sex and sexuality especially same-sex behaviours do vary across cultures and it is helpful to understand their context. As mentioned earlier, religions and consequently various religious texts influence population's attitudes. For example, various ancient Hindu texts describe same -sex attraction and behaviours (29) as part of a range of sexual activities (30) as did texts in China from the times of Yellow emperors, whose rule began in 2697 BCE, and who are said to have had same sex relationships (31) without any stigma attached to such activities. Sir Kenneth Dover had described that ancient Greece was tolerant of same sex relationships(32) who said that no act is sanctified or debased by simply having a genital dimension. Often mono-theistic religions are said to be more likely to forbid same sex relationships (33)(and yet paradoxes appear as in Mughal India where homoerotic poetry and artwork appear to have flourished(34) indicating changes in societies. Many Asian religious traditions—Hinduism, Buddhism, Confucianism, Shinto, among others—appear to have been more supportive in their attitudes to

sexual variations. These attitudes changed, moving from affirmation or relative neutrality to more negative or even hostile so-called modern views (35,36,37). As observed by Lebra, 'supremacy' of the mind over the flesh is the Western theme of morality (38) which takes things into moral and philosophical realms and this morality or lack thereof becomes a pathology requiring treatment.

In many cultures bisexuality and bisexual behaviours were acknowledged. In Hindu texts and scriptures, there have been several instances describing such behaviours. The existence, acceptance and acknowledgement of such duo-sexual identity and behaviours in the USA in its history is illustrated by identification of at least 168 still-spoken Indigenous languages which have terms for identities relating neither to man or woman (39) but to the term "two-spirit". It can be argued that these "two-spirit" people as described are believed to be closely linked with the spiritual dimension and carry with them very highly valued ancestral educational or spiritual roles (40). It is likely that many of such religiously sanctioned roles across the Americas and Africa had no possibility of continuing in the post-conquest Christian societies(41).

The cultural belief that sexuality was more than a simple procreative function was predominant in various ancient Asian cultures and countries and same sex feelings and practices was well accepted by society (42). Kamasutra (a text compiled by the Indian philosopher Vatsyayana) and Sushruta Samhita (a Hindu medical text by Sushruta), written in 600 B.C. both elaborated various sexual positions of same sex behaviours (29,42). Lord Ayappa was said to have been born out of the union of two male gods, Vishnu and Shiva. In India, it took almost 71 years to decriminalize same- sex activities after independence from the British Raj in 1947 (43).

In China, many dynasties left footprints compliant to sexual freedom. The Qing dynasty during 1644 to 1912 had a deity called Tu Er Shen who was the protector of same sex love (44). Opposition to homosexuality in China appeared to have risen during the Tang Dynasty of 618 to 907. Historians believe the rise of Christianity and subsequently that of Islam were the reasons for this opposition. Moreover, modern Asian countries Japan, Korea, Singapore, Taiwan, and Hong Kong are all rooted in the Confucian tradition with major importance attached to genealogy and ancestral lineage, subordinating same sex partnerships to a traditional' heterosexual family set-up (45). On the other hand, countries such as Singapore remain tethered to colonial attitudes where same sex behaviour remains illegal.

B) Europe

Attitudes to same sex behaviour in Europe were probably even more strongly influenced by prevalent religious mores. As mentioned earlier, the rise of Christianity led to increasing intolerance of homosexuality across Europe (10). The term 'lesbian' emerges from Greece derived from the Greek island of Lesbos where Sappho, (610 – 570 BCE), a poet who wrote poems about her love for other women (46). Traditional marriage ceremonies between two men in ancient Rome have also been described(47). Paradoxically, for a predominantly Muslim country, homosexuality has been legal in Turkey since 1858. As mentioned earlier, post French Revolution in 1791, the criminal codes against same sex activities changed to more positive ones (48). In 1956, Germany abolished the code which outlawed homosexuality, followed by Czechoslovakia in 1962 (33,48). Currently, same sex activities are legal in all member states of the EU with same -sex union (marriage or civil partnership) allowed and recognized in 22 countries (48).

C) Africa and the Middle East

African sexuality has often been stereotyped as predominantly heterosexual and promiscuous, with homosexuality considered deeply pathological and dangerous, in contrast to the west (49). However, there are many examples of non-heteronormative behavior across Africa. For example, in the northern part of Nigeria, "yan daudu" is a Hausa term used to describe effeminate men who are considered to be wives of other men(50). These practices have often been ignored by historians studying African sexualities. In 1835 there was an openly gay monarch, King Mwanga II of Uganda who actively opposed Christianity and colonialism(51). Moreover, the book entitled Boy-Wives and Female Husbands, about same sex desire in Africa, references explicit Bushman artwork depicting men engaging in same sex activities (52). Transition from boyhood to adulthood has also involved same sex sexual activities in many African tribes and ethnic groups (53). As elsewhere, the rise of colonisation and the spread of Christianity replaced previous positive cultural attitudes towards same-sex behaviours with imposition of Victorian moralities in the 19th and 20th centuries (49). Again pathologisation by religion led to these behaviours being classified as not only deviant but also as mental illnesses. At present, Africa is the continent with the highest number of countries (45 out of 46) in which same sex union is illegal (53).

Attitudes towards LGB people in Middle Eastern countries have also been influenced by the religious, legal, social, political, and cultural histories of the region. Homoerotic themes were

cultivated in art and poetry since the 8th century, but there is little evidence of tolerating same sex practices in Islamic countries (54) at present and same-sex behaviours are illegal in the region. This may be attributable to the role pf religious texts which condemn any kind of same sex practices (55).

D) The Americas

References to brutal and capital punishments for same sex activities during the 18th and 19th century and at the time of the American revolution have been described reflecting the times (56). As mentioned above, a major shift in attitudes occurred after 1960, triggering a worldwide LGBT movement. This activism can be seen as occurring alongside other socio-cultural-political movements such as feminist, anti-war and the equality rights(56). The oppression of homosexuals through raids of gay bars and other 'moral' policing eventually culminated in the Stonewall Riots of 1969 (57). The first national gay rights march in the United States took place on October 14, 1979 with over 100,000 people taking part(57). There was a further paradigm shift in the 1980s during the AIDS epidemic, (labeled and stigmatized as a "gay plague" in the media) with negative rejecting attitudes from a significant number of politicians particularly against male homosexuals (58).

In Latin America, in 1543, the first Bishop of Mexico explained same sex attraction as a deadly sin (59) reflecting both the impact of religion and colonialism. These negative attitudes continued to harden during Spanish colonisation. In 1692, people from Mexico and Peru were prosecuted, interrogated, and punished for same sex activities (59). Masculinity and its perception continue to play a major role in negative attitudes towards the LGB community. For example, passive partners are given names that carry stigma, such as *puto, joto, maricón*. And active partners were not seen as homosexual. A shift from religious to more social and medical theories about homosexuality may have contributed to some changes in attitudes in south American countries, but in spite of various progressive legislations strong sexist, gender stereotypes and widespread violence continue to create an unsafe environment for LGB individuals (60).

It is clear from this brief overview that LGB individuals have often been pathologized initially as part of a religious response and subsequently medicine's social response to medicalize and psychiatrize such practices and attempt to treat them. The impact of society and social attitudes on the practice of medicine and psychiatry in particular cannot be underestimated.

It is inevitable that discrimination and stigma related to sexual minority status is bound to affect the mental health and wellbeing of lesbian, gay and bisexual individuals who are consequently seen as deviant and hence ill. In the following section, we look at the relationship between mental health science and sexual orientation.

Medicalisation of same-sex behaviours

Medicine and psychiatry both have their own cultures, languages, ways of thinking, values, and tend to carry certain authority (61) not dissimilar to that exhibited by religions. Society identifies, defines and dictates what is normal and what is deviant and medicine and psychiatry tend to follow this through medicalisation of "normal variant" sexual desire and expression. It may be to do with power but also in certain settings the alternative might be too extreme and professionals may choose to exercise this power in what they see as benevolent way. When individuals who are attracted to the same sex are defined as 'unwell' or 'ill', it follows that 'treatments' can be 'prescribed' by the society and psychiatrists as the agents of the state deliver these. In the past these interventions have included aversion therapy (e.g. electric shocks, apomorphine induced vomiting), oestrogen treatment to reduce libido but also religious counselling (62). Many countries continue to offer these to this day. Not surprisingly, more privileged men were often offered the "softer" alternative of treatment rather than jail if caught in same-sex behaviours (63). It is worth recalling how mental illnesses can be taken out of classificatory systems. John Fry – "Dr H Anonymous" a gay psychiatrist raised the issues of discrimination faced by gay psychiatrists in their own profession in the 1972 American Psychiatric Association (APA) meeting. This led to a debate on, "Should Homosexuality be in the APA Nomenclature?"(18) in 1973. The vote to eliminate Homosexuality per se as a mental disorder and to substitute a new category titled Sexual Orientation Disturbance was approved by the Board of Trustees of the APA in December 1973. This was followed by a general member vote where core members of the APA voted to remove homosexuality from the DSM. In May of 1974 the trustees' decision was upheld by a substantial majority of the voting members of the Association. Thus theoretically millions of people around the world were cured at the stroke of a pen. Yet these changes did not enter or alter medical curricula which remained unchanged for years and continued to use discriminatory adjectives towards same sex attraction (64). In 2016, Bhugra and colleagues launched a position statement on same sex behaviour from the World Psychiatric Association urging the decriminalisation of same-sex sexual orientation and behaviour and to recognise LGBT rights (65). These statements have had some impact and galvanized some member societies to publish their own position statements on same sex behaviour. However, only eight

countries have officially banned “Conversion Therapy” (66) whereas at the time of writing a bill is going through parliament in Ghana making conversion therapy treatment for same-sex attraction. In 2017, the Royal College of Psychiatrists in the UK acknowledged the harm done to lesbian, gay and bisexual people through “conversion therapies” (67). The impact of conversion therapy cannot be underestimated contributing to further stigma and discrimination. Conversion therapies do not change the innate nature of sexual orientation but may change the behaviour only. Thus it will be helpful to look at identity formation. :

It is helpful to recognize and understand how sexual identity is formed and how individuals and their families at immediate proximal level and social and cultural factors at a distal level may play a role.

Sexual Identity Formation

The formation of individual identity is a complex phenomenon in itself. Sexual identity carries with it additional factors including social attitudes, discrimination or acceptance. The subject of sexual identity tends to incite strong emotions, reactions and debate, reflecting social and political interests and contentions. In particular, the concept of “choosing to be gay” takes on a major import both for the individual and for the society as a whole.

Biological Theories

The influence of biology on the development of sexual identity generally focuses on the role of sex hormones (antenatally and postnatally), neuroanatomical differences, and genes. For example, research has identified differences in size and neural numbers in the third interstitial nucleus of the anterior hypothalamus (INAH-3) between heterosexual and non-heterosexual men, and varying degrees of hypothalamic activation between heterosexual and non-heterosexual men and women when exposed to pheromones (68). Swaab noted that some brain structures are also influenced by sex hormones (for example, androgen exposure), particularly during the developmental period, and posited that this can influence the development of sexual identity and gender identity variations(69). Bogaert and Skorska’s review of research in the field, noted that genetic studies show some support for heritability, gene markers, epigenetics and genetic variants associated with same-sex orientation (68). They also described the Fraternal Birth Order Effect (FBOE) a phenomenon where same sex attracted men tend to have a greater number of older brothers compared with heterosexual men. Although there has been significant progress in recent years in our understanding of the biological underpinnings of sexual orientation, many areas including

female sexual orientation, bisexuality and asexuality are not well understood and the interplay between biology and social mechanisms of causality often remains speculative.

Psychological Theories of Sexual Diversity

Although several psychological theories of sexual diversity have been hypothesized, often these tend to reflect strongly prevalent societal norms and orthodoxies which appear to emphasize psychopathologies. Thus, inevitably there have been numerous theories from psychoanalytic, behavioural and learning perspectives as well as hypotheses related to psycho-biology. The majority of these have been developed in Western settings and have focused on male same-sex attraction. This may reflect the historic societal view (70).

Psychoanalytic theorists and even some behaviourists postulated that men who experienced same sex attraction were feeble and unable to adopt society's view of masculine behaviour (71). These findings are disputed by social and historical evidence. Churchill and Dover have described same sex relationships across history and cultures, going back to the ancient Greeks (72,73). Of note, Plato bestowed the virtues of same sex attraction in the military on the basis that soldiers would be likely to fight harder in order to protect their lovers. This goes against the prevalent norms in many countries prohibiting homosexuals from joining the army. Freud postulated that all humans are born as bisexual beings and are biologically capable of experiencing sexual arousal with both males and females. He attributed this to an "inverted" Oedipus complex, where male individuals may identify with their mother or maternal figure and see themselves as a love object (74,75). Although Freud did see homosexuality as a result of a lack of resolution of oedipal complex in his famous letter to a mother he normalized this. On the other hand, Havelock Ellis saw development of male same-sex attraction as a result of societal restrictions and believed that such attraction was simply another manifestation of the sexual impulse, and hence a natural part of the human experience (76). These theories have to be seen as the product of their time.

Kinsey et al reported (surprisingly) high rates of non-heterosexual behaviour in the USA population. This may have reflected not only changing attitudes towards sexual behavior in the post-war period when their survey was carried out (77) but also recorded opportunistic same-sex behaviour in the armed forces. Bieber et al compared the health records of male same-sex attracted individuals (n=106) and male heterosexual individuals (n=100) and reported that the same-sex attracted males

typically had over-controlled, inhibiting maternal relationships and emotionally distant, and hostile fathers (17). Although problematic, like many studies which blame parents (especially mothers!),this study had several problems. The sample was from Bieber's clinical practice and was not representative and highlighted the contribution of environmental factors on sexual orientation(17,78). Further progress towards destigmatizing homosexuality came from Evelyn Hooker, an American psychologist, who was emphatic that a non-heterosexual identity should not be seen as a clinical disorder (79). The mainstream view held by mental health professionals and researchers today, particularly in high income countries, is that non-heterosexual identities are not psychopathological but normal variations of the human sexual experience.

Sexual identity development starts during childhood or early adolescence (80). Various theories suggest that the impact of an individual's first sexual experience can cause a type of imprinting, with the premise that one's sexual orientation needs to be tested or confirmed before consolidation into a life-long identity (81). However, non-heterosexual self-identification often occurs prior to any actual sexual experience as a part of an "identity-centred" pattern of development. This debate regarding sex-centred or identity-centred pathways continues. For example, Floyd and Bakeman (82) reported that LGB participants in their study were more likely to have had identity-centred development. Social identity or collective identity (identifying self as being part of a large social structure or group) are related to acceptance by that larger group and subsequent integration of non-heterosexual identity into a broader social self. This in turn is likely to influence expected and given social support to the individual. Identity thus is not only how individuals see themselves but also how they see others seeing them .

Have a clear idea of the population that is being served including how many individuals live in that particular geographical area and the level of their healthcare needs. It is well recognized that individuals from minority groups often shy away from seeking help because of perceived and expected stigma. Another possible factor is that same sex attracted individuals may be able to hide their orientation unlike race or skin colour and thus levels of need may be under-reported. Hence a key step is to understand the base population and approximate population size.

Prevalence of sexual minorities

There are problems in gaining accurate data on the number of people from sexual minorities in different populations and across cultures due to varying degrees of social and cultural openness. Consequently, in many settings there is a great reliance on population size estimation strategies to assess the numbers of LGB people (83). LGB individuals are distributed throughout the population (84) and across all age groups, hence it is critical that planners are aware of their numbers and health needs when designing and delivering services. Population-based surveys and social behavioral research must therefore continue to expand and improve the measurement of sexual orientation identity (69). LGB individuals face multiple barriers in seeking healthcare at both the structural and individual levels (85) including internalised stigma and external discrimination both of which further impair openness and access to services. Since key health disparities exist for LGB adults, sexual orientation can, and indeed should, be effectively included as a standard demographic variable in public health surveillance systems to provide data that support planning interventions and progress toward improving LGB health (86).

Having accurate measures and estimates of sexual orientation and behaviors in the population is essential for design, development and delivery of sensitive services but can also help inform policy. Government surveys with sexual orientation measures can help increase awareness for policymakers and the general public. An absence of LGB identities in most of the recurrent national surveys by official statistical agencies means that the social situation of LGB people often remains invisible (87). There are often local variations as many LGB individuals may choose to move to cities for anonymity and other reasons. Since concealment can exact deep mental and physical health costs and dampen the public visibility necessary for societal change, knowing the size of the global closet represents a major public health question with important and clear policy implications (88).

Several concepts can be used to measure sexual orientation: identity (whether a person considers himself or herself to be heterosexual, homosexual or bisexual), behaviour (whether a person's partner or partners are of the same, the opposite sex, or both sexes), and attraction (whether a person is attracted to a person of his or her own sex, the other sex, or both sexes). Each of these dimensions can be assessed independently or in combination to measure the prevalence of sexual minority status in the general population (89). Various survey methods can affect the willingness of respondents to report stigmatising identities and behaviors (90). Population counts of LGB have included both in-person and on-line surveys with a greater reliance on on-line strategies (83) which

allow a sense of privacy and confidentiality thus likely to lead to openness. Current estimates – even though elicited under privacy and anonymity – are likely to be underestimates (91). In an interesting departure, a method leveraging different categories of same-sex interests on Facebook, combined with a specific gay dating app demonstrated significantly higher estimates than those officially reported (83). It has been shown that subjects report the highest mean comfort level with anonymous online surveys with questions about their sexual orientation and the lowest with non-anonymous personal interviews (92) as often they disclose their orientation or behaviour to a select group of people. Not surprisingly, approaches to LGB people to identify themselves are more difficult in countries where homosexual behaviour and homosexuality are less tolerated or criminalised. This issue reinforces a data paradox: we know the least about the numbers and social experiences of the most vulnerable communities of LGB in settings deemed the most hostile (83). A recent survey by Gallup in the USA has shown the rates of LGBT populations to be 5.6% up from 4.5% in 2017 but interestingly the number of people who chose not to answer was also up indicating that there is still some reluctance in acknowledging sexual orientation (93) or behaviours which may be seen as problematic.

Challenges in research:

Research methods to measure rates of sexual orientation vary greatly (94), thus making direct comparisons across cultures and societies and subsequent analysis and interpretation challenging. These variations include sample selection, the way questions are phrased, and the degree of privacy and anonymity afforded to participants when answering these questions (91). This is further complicated by a lack of consensus among experts on what questions to ask or how to frame questions about sexual orientation (95). Any questions about one's sexual orientation are particularly sensitive due, in part, to a specific form of social desirability bias of heteronormativity (92). On the other hand, some LGBT organisations are opposed to data collection because they prefer to protect the individual freedom to choose whether or not to disclose their sexual orientation (87).

Some of the challenges encountered when collecting data on LGB people are as follows:

1. Confidentiality and anonymity: Given that many people only disclose this to a limited group of people, gathering data on LGB experiences remains difficult. It has been observed that the estimates of non-heterosexual prevalence in the US increased as the privacy and anonymity of the survey increased (92). Sexual minority status itself is stigmatised, thus, survey research

participants may consider questions about sexual orientation to be “sensitive” and may not disclose their sexuality status to researchers (95). Individuals may fear direct harm to them or their families as a result of such disclosure. Consequently, behaviors, beliefs, or identities that could be perceived as sensitive or unpopular are typically likely to be underreported (91).

2.Representativeness: Most population studies have been conducted in the North American continent, Australia, and Western Europe, which cannot and should not be seen as representative of global LGB populations. As mentioned above, variations in estimates of sexual behavior and sexual orientation across surveys reflect differences in the actual wording of the questions as well as survey design (96) thus under-reporting may occur (97). Often a lack of objective measurements of sexual attraction, fantasies, behaviours or identities due to the discreet and somewhat subjective nature of sexual orientation can also make assessments difficult (92). Differing sample sizes of surveys are likely to add further variations in findings (89). It would appear that people are more willing to answer questions about identity than about behaviour (98). Increasingly younger people are reporting high levels of sexual fluidity (83,99,100)reflecting changes in societies and social attitudes.

3. Categorisation: The classification of lesbians, gays, and bisexuals within research studies is generally made on the basis of sexual orientation (84). As discussed earlier, attraction, behaviour, and identity are three aspects of sexual orientation that may not always correspond. Same-sex behavior and sexual attraction may not always match an individual’s sexual identity (94,96). As noted earlier, in many settings and languages words for non-heterosexuals are deemed derogatory so people may not respond to these (101). Thus non-response as a result of stigma of identification and non-understanding can play a role in under-reporting and under-recording (102).

4. Structural stigma: It has been shown that the degree of structural stigma related to sexual minorities can predict the proportion of sexual minorities who openly express their sexual orientation (88). Pachankis and Bränström(88) in a study from 28 countries estimated that a majority of sexual minorities conceal their sexual orientation from all or most family, friends, colleagues, neighbors, and medical providers. They observed that factors such as country-level structural stigma, discriminatory laws and policies (denying equal rights to sexual minorities) can be useful predictors of the size of each country’s closeted sexual minority population.

A final challenge to demographic estimates of the LGB community is a lack of regularly repeated large, representative surveys that repeat questions about sexual orientation over time using a

consistent method and sampling strategy. Adding questions about sexual orientation to more large-scale surveys that are repeated over time would substantially improve our ability to make better estimates of the size of the LGB population (89). The recent census in the UK in 2021 has introduced questions on sexual orientation. It will be interesting to see whether it makes a difference in the rates in subsequent censuses.

In order to deliver appropriate and accessible healthcare which meets the needs of the population being served, not only is it helpful to know the base population but also rates of various psychiatric disorders. This allows a clear picture to be formed so that adequate resources can then be allocated. Thus it is helpful to know rates of various psychiatric disorders in the LGB population.

Prevalence of psychiatric disorders:

In spite of concerns about methods of data collection and difficulties in being certain about the base population, rates of mental illnesses in lesbian, gay and bisexual people have been shown to be consistently higher than heterosexual population. Again as the vast majority of studies have been conducted in Anglo-centric and high-income countries, little is known about the situation in many lower income and non-white majority cultures.

In a systematic review, King et al. (103)reported a two-fold excess in suicide attempts in LGB individuals over the comparator heterosexual people but with higher levels in gay and bisexual men. LGB individuals also reported significantly higher levels of depression, anxiety and alcohol or substance dependence in the previous year or over lifetime in comparison with heterosexual controls, lesbians and bisexual women were at higher risk of alcohol and substance abuse.

Another review showed significantly higher rates of suicidality and depression in sexual minority youth compared with heterosexual youth (104). A more recent large on-line survey of 40,000 LGBTQ+ youth in the USA, reported that the prevalence of suicidal thoughts and acts was high (47% suicidal ideation, 20% suicidal acts) but very similar to the general population under 18 years (105) which may reflect societal changes. These findings require further exploration. Miranda-Mendizábal et al in a systematic review also reported a higher risk of suicide attempt amongst LGB adolescents (106). Semlyn et al (107) reported that those individuals identifying as lesbian or gay were at a

higher risk of common mental disorders than heterosexuals, with younger and older people at greatest risk.

The risk of mental health problems seems to be especially high amongst bisexuals who had a higher risk than lesbians and gay men on suicidality, and for female than male bisexual individuals (108). The Swedish National Public Health Survey (109) also found an elevated risk of co-occurring psychological distress and substance use amongst gay men compared with heterosexual men and bisexual women relative to heterosexual women. Experiences of discrimination, victimisation, and social isolation were identified as partially explaining these findings.

A recent survey with 2200 people self-identifying as belonging to a sexual minority in Kenya and South Africa, Lesotho and Eswatini (formerly Swaziland) reported a very high prevalence of depression (46-57%), anxiety (55-66%), suicide attempts (22-27%) and substance misuse (17-19%) (110) . Whereas homosexuality is illegal in Kenya and sodomy is illegal in Eswatini, the constitution of South Africa proscribes discrimination on the basis of sexual orientation and same-sex unions are legal. This survey confirmed the relationship between high rates of psychopathology and negative social attitudes.), Through national population-based datasets from 2015 and 2016, Schuler et al (111) also confirmed an elevated risk of alcohol or substance use disorders amongst LGB population. Elmslie et al (112) in a qualitative study from Scotland observed that heavy drinking was linked to the commercial gay scene and the type of drink was thought to play an important (if stereotypical) role in people's identity. These authors reported that gay men tended to drink alcopops and cocktails while lesbians tended to drink pints of beer. However, Schuler et al (113) using data from the 2015-2018 United States national survey on drug use and health found ethnic differences in rates too. They reported that lesbians and bisexual women had a higher prevalence of heavy episodic drinking than heterosexual women, and the difference was greater for black and Hispanic compared to white lesbians and bisexual women. Conversely, gay and bisexual men from racial/ethnic minorities were not found to have a greater risk of substance use relative to their white gay and bisexual counterparts. These authors propose that differential minority stress might explain these findings, in that the risk of substance misuse was exacerbated by the stress associated with belonging to multiple minority groups - being female, from a black and minority ethnic group and being lesbian or bisexual. Minority stress is crucially important in understanding differential rates of various mental illnesses in LGB populations. For ethnic minority individuals who are LGB, it may act as double jeopardy.

Minority stress has been put forward as a potential explanation of higher than expected rates of psychiatric disorders in minority groups be they race/ethnicity minority or sexual minority groups. It is likely that further negative societal responses to minority status can contribute to further distress. Although the principles of minority stress hypothesis can be applied to all minorities but here we shall focus on the impact of such stress on LGB individuals

Minority stress hypothesis

Sexual minority status is one of the many factors that influences people's health. Among various hypotheses to explain high rates of psychiatric disorders in LGB populations is the minority stress hypothesis (114). It includes both distal and proximal stressors. Distal stress processes are external factors to the minority individual, like experiences with rejection and discrimination as well as perception of these. Proximal stress processes are internal, which includes concealment of one's (sexual) minority identity (whereas other visible minority status may be more difficult to hide e.g. gender, ethnicity or religion), vigilance and anxiety about prejudice, and negative feelings about one's own minority group (114,115). This theory posits that social and environmental stress may lead to mental and physical ill effects. Minority stressors exist on a continuum of proximity to the self, ranging from internalised stigma to various discriminatory social laws and policies. This concept is now further demonstrated with the relevance of cultural and ethnic backgrounds to complement the application of intersectionality in research on health disparities experienced by LGB people (116). Most of these studies use internalised homophobia as a measure of minority stress. In a recent study from Australia, Bartos et al found that negative messages from opposers of the campaign for same sex union acted as a form of minority stress for those from sexual minorities (117). LGB individuals face chronic stress due to homophobic and heterosexist social conditions that are associated with higher rates of mood, anxiety, or substance abuse disorder during the life time or currently (115).

Factors contributing to minority stress and a negative impact on mental health are:

a) Stress of having a particular (minority) identity: The importance of having a particular identity can itself create a sense of distress (118). This minority identity may also lead to over-identification with the minority community and/or rejection of the majority community, further contributing to a sense of alienation which further contributes to stress (119) thus setting up a vicious circle.

b) Internalised Homophobia: Negative societal (and family) messages about LGB people create negative self-image and beliefs (120). Attitudes of the family towards same-sex identity can lead to rejection or acceptance rarely neutrality. These can create a culture conflict within the family which could be more severe in socio-centric cultures. Such a rejection or non-acceptance can lead to feelings of depression, anxiety, shame and inferiority which may be further compounded by a lack of protection from parents/family, and social rejection, all of which exacerbate victimisation in the face of homophobic violence (121).

We shall illustrate prevalence of some of the psychiatric conditions related to minority stress below.

A) Minority Stress and alcohol abuse

LGB victimisation and internalised homophobia have been shown to exert direct effects on substance use (122,123). Following shooting at a gay nightclub, in 2016 in Orlando (which has been the deadliest attack on a LGBT venue in the US history), it was reported that the use of alcohol and drugs increased among LGB individuals in order to cope with stress (124). This was an online survey and the sample included LGB individuals from across the country. From a systematic review of 12 studies, Goldbach et al reported an increased use of marijuana among sexual minority adolescents (125). Various risk factors related to this increased use were victimization, lack of support, psychological stress, internalizing/externalizing factors and housing status. Thus feeling minority stress may lead to abnormal coping mechanisms thereby using alcohol or substances.

B) Minority Stress and body image concerns

Gay men's experiences of minority stress and their conformity to masculine norms have been shown to be associated with dissatisfaction with body image (126). In this study, minority stress factors (internalized homophobia, stigma, and anti-gay attacks) were found to be significantly associated with body image dissatisfaction. In a study in the US, 50% of the LGB population were noted to have body image concerns related to minority stress (127). These authors found that the effects of minority stress in sexual minority youth were moderated by community involvement and noted that all minority stressors and community involvement were positively associated with increased odds of disordered body image behaviours and concerns which highlight the role of community involvement and expectations. Mensinger et al reported that sexual and gender minorities had higher rates of eating disorders which they attributed to sexual and physical abuse and trauma

related to bullying (128). Thus, a complex picture about the causation and development of eating disorders and body image in relation to minority stress starts to emerge.

C) Major Depressive Symptoms & Minority Stress

Feeling like a burden to "people in their lives" has been shown to be a critical mechanism in developing high levels of depression and suicidal ideation among LGB youth (129) and among sexual minority women (130). The latter study reported that there existed direct links between victimization and substance use and between internalized homophobia and substance use. Cognitive factors, such as negative expectations for the future have been strongly associated with elevated levels of hopelessness and depression and as discussed earlier, rates of suicidal ideation and suicide were higher among LGB individuals and these cognitive factors may contribute to these rates.

D) Psychological distress and rumination

The influence of sexual minority stressors have been found to be associated with ruminations about sexual minority stigma leading to disordered eating patterns (131). The pathway from expectations of rejection to this rumination (which can be seen as a psychological defence mechanism) and from self-stigma to distress have been shown to be stronger for men than for women (132). Rumination has been shown to be an important area of intervention for clinicians treating LGB individuals with depression (133). Sexual minority stressors are thus capable of compromising well-being even if not subjectively appraised as stressful (134). It would appear that minority stress contributes to mental ill-health and reduces well-being. The challenges lie in changing the social factors which contribute to stigma and negativity.

There is considerable research evidence suggesting that once individuals gain equality in law, rates of many psychiatric disorders start to diminish. This is likely to be a result of recognition as equal but also adding to a sense of increased self-esteem. There is impressive evidence to suggest that once equality is brought in, rates of psychiatric disorders start to drop also confirming the role social factors play in the genesis and perpetuation of psychiatric disorders.

Equality reduces stress and rates of disorders:

Sexual minorities living in communities with high levels of anti-gay prejudice experience a three times higher hazard of mortality than those living in low-prejudice communities and have a shorter life expectancy of approximately 12 years (135). There is clear evidence that addressing this differential can reduce health disparities among stigmatized groups (136). In particular, it has been shown repeatedly that protective policies (reducing hate crimes, addressing employment discrimination through sexual orientation as a protected class) can lead to a reduction in rates of mental health problems (137,138).

LGB-inclusive policies also have a positive impact on mental health outcomes in sexual minority populations. Individual and community-based interventions aiming at greater inclusion of sexual minority persons, promoting resilience and managing minority stress are likely to improve the gap of mental health disparities in both the short and mid-term (121) but also in the long-term. In order to mitigate the pernicious effects of sexual minority stressors on mental and physical health, efforts have to be made both to reduce the frequency and severity of social stressors faced by LGB individuals and to bolster their stress coping resources (134).

As illustrated in the map of the world above, the status of sexual minority individuals varies across nations. It raises specific challenges in equality but also the relationship between inequalities and rates of psychiatric disorders and patterns of help-seeking behaviours.

Legal issues around the globe:

Globalisation and favorable global cultural messages may have had some effect on changing negative attitudes and laws in some countries although the impact appears less pronounced in other more religious societies (139). According to the estimated Homophobic Climate Index for 158 countries incorporating institutional and social components of homophobia, Western Europe is the most inclusive region, followed by Latin America, while Africa and the Middle East are home to the most homophobic countries with two exceptions: South Africa and Cabo Verde (140). Some countries seem to be taking steps backwards which will increase stigmatization and diminish the hard-won legal rights of sexual minorities (141,142) along with worsening mental health which may contribute to poor physical health and increased mortality.

According to the UN International Covenant on Civil and Political Rights Article 6 (143), “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.” While the Article does not prohibit the possibility of the death

penalty in countries where such a legal procedure still exists, it clearly states that “sentence of death may be imposed only for the most serious crimes” (ICCPR, 1966). The UN Human Rights Committee General comment no. 36 on ICCPR Article 6 states that the term “the most serious crimes” must be read restrictively and appertain only to crimes of extreme gravity involving intentional killing. This comment also clearly indicates that “under no circumstances can the death penalty ever be applied as a sanction against . . . homosexuality”. In 2017, the UN Human Rights Council (144) issued a resolution condemning the imposition of the death penalty as a sanction for consensual same-sex relations and urged member states that have not yet abolished the death penalty to ensure that it is not imposed as a sanction for specific forms of conduct such as consensual same-sex relations. However, according to the ILGA World report (145), among those countries which criminalize consensual same-sex conduct (67 UN Member States), the death penalty is the legally prescribed punishment for consensual same-sex sexual acts in six UN Member States, namely: Brunei, Iran, Mauritania, Nigeria (12 Northern states only), Saudi Arabia and Yemen. There are also five additional UN Member States where certain sources indicate that the death penalty may be imposed for consensual same-sex conduct, but where there is less legal certainty on the matter: Afghanistan, Pakistan, Qatar, Somalia (including Somaliland) and the United Arab Emirates. Countries that still impose the death penalty for consensual same-sex sexual activity are ruled by Sharia law – an ensemble of ethical and moral codes stemming from Islamic tradition (145). Other legal discrimination against LGB people can take forms, such as criminalizing pro-LGB events held in public places or denying same-sex couples the right to marry. At the core of these is the power differentials between heterosexual and non-heterosexual citizens which are then sanctioned and perpetuated by state legal acts (146).

Health care needs of sexual minority individuals require not only special attention related to reduction and elimination of stigma but increasing acceptance on part of medical profession by ensuring access to safe spaces where individuals seeking help can feel comfortable.

Therapeutic Interventions

From the discussion above, it is evident that LGB individuals are more likely to experience higher rates of certain mental illnesses but they are also less likely to seek help as service providers may hold negative attitudes due to psychiatry’s long history of pathologising homosexuality. Even though homosexuality is no longer considered a mental illness in many countries, the stigmatising attitudes of the general population and policymakers towards LGB people continue to feed into negative

attitudes of those delivering healthcare. These combined with structural prejudice, bias or simple ignorance can easily alienate LGB individuals.

Although patients tended to report greater benefits from the therapy when their therapist was of the same sexual orientation as them, the qualitative evidence suggests that therapists' attitudes, knowledge and skills remain more important than their sexual orientation (147). It is important that therapists should not rely on their client to educate them, partly because of the extremely personal nature of experiences which may not be easily generalizable but also it may erode therapy time and consequently alienate the client. In any therapeutic interaction client/patient is at the core and their personal experiences must remain the most important focus and generalisations must be avoided. Therapists who were more informed about the lifestyle and culture of people from sexual minorities were less likely to make heteronormative assumptions or to assume that the client had sought therapy because of their sexual orientation. As in the case of training in cultural competence, therapists need to be aware of their personal anti-homosexual biases, whatever their own sexual orientation and deal with them.

In a recent systematic review on the experiences of mental health services by sexual minorities, McNamara and Wilson found that in over two thirds of the studies which had been included, clinicians appeared unaware of sexual minorities' cultures (148). A more worrying finding was the discomfort of clinicians or their dismissiveness when discussing sexual orientation which meant that their clients felt judged or poorly understood. Good general counselling skills (such as openness, compassion and validation) and adoption of an affirmative approach, such as asking clients proactively about their sexual orientation rather than making assumptions, and avoiding heteronormative language were recognized as important. An affirmative approach is therefore, essential in order to form an effective therapeutic alliance. Alessi et al. confirmed that an affirmative approach with LGB individuals was positively associated with their psychological well-being (149). It is crucial to have appropriate research funding to measure and ascertain satisfaction and clinical outcomes for LGB people (150) and to ensure that any research is being carried out properly. O'Shaugnessy et al (151) in their mixed-methods systematic synthesis observed that various affirmative approaches to address problems such as substance misuse, depression, eating disorders, and suicidality, largely reported positive outcomes. However, most worryingly a majority of the quantitative studies included in this review focused on gay and bisexual men and none were specific to lesbians or bisexual women.

The American Psychological Association published its initial guidance in 2012 (updated in 2020), recommending training in gaining knowledge about sexual minority cultures, working affirmatively with people from sexual minority groups, using inclusive language, and participating in reflective practice to address conscious and unconscious bias. Similar initiatives have come from other organisations e.g. the Psychological Society of Ireland and the British Psychological Society (152,153,154).

So-called conversion therapies have been used in psychiatry for decades using aversion therapies, medication to reduce libido and other methods. The term conversion therapy is fraught with difficulties hence we prefer to add so-called as prefix.

So -Called 'Conversion Therapies'

It is evident that the step of removing the diagnosis of "homosexuality" from the DSM did not end the era of the pathologization of homosexuality, as a new diagnosis of Sexual Orientation Disturbance was introduced into clinical practice, which in turn may have contributed to the ongoing legitimization of the practice of so called 'conversion therapies'. This again reflects the role psychiatry, psychiatrists and psychologists play in responding to societal concerns. Conversion therapy is an umbrella expression to refer to any sustained effort to modify a person's sexual orientation. It is important to point out that there is no sound scientific evidence that innate sexual orientation can be changed (22,65) and, more importantly, the provision of any intervention purporting to "treat" something that is not a disorder is wholly unethical (65). In the last thirty years, more than 65 national, regional and international professional associations have adopted specific position statements against the administration of so-called "conversion therapies". Most of them elaborate on the lack of evidence to support their effectiveness, the risks of clear harm, and the ethical implications of offering these "therapies" (142). Furthermore, these conversion therapies are often propagated by churches and religious leaders in many countries, also see below. In addition, the availability of so-called treatment options for homosexuality contribute to the ongoing discrimination and stigmatization of sexual minorities within healthcare delivery. These factors are associated with a high risk of harm to the subject and society. Although in many western countries, activism has brought about change and equality, in other countries it has proved to be a risky proposition (145). Equally importantly, a failure of activism can impede change (146). Serovich et al. in a systematic narrative analysis of the literature on 'reparative therapy' (another term for

'conversion therapy') identified a number of methodological problems suggesting that scientific rigor in these studies is lacking (155).

However, basing their ideology on the mid-20th-century psychoanalytic theories and Christian theological assertions of the complementary nature of men and women, so-called "ex-gay ministries" have been established, mainly in the US (156) aimed at the "treatment" of same-sex attraction. Across the US, approximately 57,000 13 to 17-year-olds are projected to engage in 'conversion therapy' with a spiritual or religious counselor (157). It is unclear whether these are self-referrals or whether individuals have been encouraged or even pushed to seek 'help' in this way.

As conversion therapies can be harmful, there is no research rationale for clinicians to provide these therapies. Mental health professionals have a moral and ethical duty and a social responsibility to advocate for a reduction in social inequalities for all individuals, including inequalities related to sexual orientation (158). In order to advocate for patients and the services their patients need, clinicians must learn to put aside their personal prejudices and through their professional organisations attempt to change negative societal attitudes which impede equality which means dropping any type of conversion therapies. This is confirmed by the concerns raised by Radden (159) about a clinician's "built-in framing . . . parallel to the (other) hidden value assumptions," when his or her religious beliefs, among others, inadvertently guide their clinical practice in ways which are not in the patient's best interest. If a clinician's knowledge about human sexuality is scarce and—rather than referring to reliable scientific sources—outdated theories or personal beliefs are being relied upon, many clinical and ethical concerns are likely to emerge (160). Prejudicial and stigmatizing attitudes are unacceptable in clinicians.

Although 'conversion therapy' is strongly opposed by many prominent national and international healthcare organisations, including the World Psychiatric Association (65), some licensed mental health professionals continue to provide highly unethical clinical interventions in order to attempt to change their patients' sexual orientation (161). In addition to the review by Serovich et al (155), another systematic review has clearly illustrated that efforts to change sexual orientation are largely unsuccessful and scientifically unfounded, whereas studies showing minor changes are methodologically flawed (162). More significantly, trying to change one's sexual orientation is associated with significant (iatrogenic) psychological and spiritual damage, often aggravating the reconciliation of sexual and religious identities (162). A number of other professional associations have recognized and ratified equality in human rights which can create a more equitable distribution of resources (67, 163). This will enable better health through increasing institutional accountability

for discrimination, decreasing state-sponsored repression of LGB individuals, (among others) and thereby decreasing social stigma (164).

Although over the past decades religiosity has declined in many high-income countries, people across many parts of the world continue to consider religion to be important (165,166). However, globally the proportion of religious adherents is projected to increase (167) rather than diminish due to demographic changes. As discussed in an earlier section, major religions tend to discourage non-procreative sexual behaviours, with the evidence indicating more homonegative and bi-negative attitudes among those with religious beliefs (168,169). These negative attitudes reflecting many religious interpretations then influence psychiatric practice and create further stigma and negative attitudes. For many LGB persons, particularly in the early stages of sexual identity formation, the reconciliation of sexual and religious domains may well be very distressing and confusing and such a conflict, if unresolved, may be associated with higher internalised homonegativity and consequently poorer mental health (170,171). Nevertheless, rather than being mutually exclusive, religious and non-heterosexual identities seem to interdigitate in more complex and ambiguous ways (171). As argued by Page and Shipley, comparing religion (seen as "oppressive and archaic") on the one end of the spectrum and secularism (seen as "liberating and rational") on the other, may not be as straightforward as it seems (172)even though it appears an attractive option, as there are many shades in the middle. Many LGB individuals manage perfectly well to integrate their sexuality with religious beliefs even when the official stance of their religion—as is generally true for major monotheistic religions—is unwelcoming (171). Indeed, as suggested by Peteet, rather than trying to rescue a spiritually distressed patient from a "dysfunctional set of [religious] beliefs," a mental health professional can support the patient—with equal respect for their values, beliefs, and sexuality—in finding spiritual resources within the patient's faith (173).

There have been important developments with regard to guidance for professionals in relation to so called 'conversion therapies.'. For example, in the UK, a Memorandum of Understanding was published by the British Association for Counselling and Psychotherapy (BACP) in 2017 which has now been signed by 20 organisations representing counsellors, psychologists and psychotherapists, as well as statutory bodies such as NHS England, NHS Scotland and the Royal College of General Practitioners with the stated aim of ending the practice of conversion therapy (174). However, a legal ban has still not happened. A similar resolution was passed by the American Psychiatric Association in collaboration with Association of Gay and lesbian Psychiatrists (AGLP) in 2009 to

oppose “sexual orientation change efforts practised by therapists, often associated with faith organisations, to address a concept of homosexuality depicted as symptomatic of developmental or spiritual failings” (175). Most of the major mental health professional organisations in the US have also published similar statements.

In May 2020, the United Nations (UN) reported that 700,000 people in the US had experienced some form of conversion therapy and that globally it was being practised in at least 68 countries, often on minors, and was particularly common in Africa (176). The vast majority of those who had been exposed to it, reported that it had caused them psychological harm and often described it as a form of torture - in Mozambique, for example, it included ‘corrective rape’ for lesbianism. The UN has called for a global ban on all conversion therapies (176) but currently, this is only in place in five countries (Malta, Brazil, Ecuador, Taiwan and Germany).

The global body of psychiatrists – the WPA - considers same-sex attraction, orientation and behaviour as normal variants of human sexuality. In its statement, the WPA recognized the multi-factorial causation of human sexuality, orientation, behaviour and lifestyle. It also acknowledged the lack of scientific efficacy of treatments that attempt to change sexual orientation and highlights the harm and adverse effects of such therapies (65).

In the UK, there have been recent policy initiatives aimed at improving access to mental healthcare for people from sexual minorities. In 2018, the UK Government published an action plan on ‘Improving the lives of Lesbian, Gay, Bisexual and Transgender people ’which included the appointment of a national adviser ‘to improve healthcare professionals ’awareness of LGBT issues so they can provide better patient care’(177). One of the cited actions was to improve mental healthcare for this group and, for the first time, to ensure people from sexual minorities were included in the national suicide prevention strategy as a high-risk group (177). Further plans include the education and training of all NHS staff to improve cultural competence in working with people from sexual minorities. Healthcare providers in the UK, are now expected to ensure that sexual orientation is specifically included in staff diversity training and in the organisation’s anti-discrimination policy. Additional initiatives that demonstrate an inclusive organisational culture are increasingly common, such as providing rainbow lanyards for staff to wear, publicising how the organisation works with people from sexual minorities, and providing support groups and champions for staff from sexual minorities. These interventions really can’t come soon enough, as evidenced by McCann and Brown’s recent investigation of the experiences of lesbians who had accessed mental health services in Northern Ireland, where one participant reported (178):

'then I saw the psychiatrist… when I did say something about my sexuality to him, he was kind of like "oh but you're so pretty"… like "oh but you're beautiful, you'll find a man and everything will be fine for you." I was like, seriously…'

Equally important to note that these negative attitudes towards lesbians are prevalent across nations and reflect negative, patronizing and patriarchal views. In 2020, a 21 year old Indian woman, who identified herself as lesbian, posted a video mentioning how she was put on heavy medication without her consent. She subsequently died by suicide (179). This tragedy illustrates in graphic terms how far psychiatry still has to go to offer a truly "affirmative approach" to people from sexual minorities.

LGB mental health professionals and challenges:

There have been surprisingly few studies investigating the mental health and experiences of doctors and other health professionals from sexual minorities and none that have specifically investigated LGB mental health professionals. A study from the USA reported that two thirds of LGB doctors feared losing referrals from their colleagues if they were open about their sexual orientation and one third had experienced verbal harassment or insults from colleagues because of it (180). Only 12% felt that they were treated as equals within the profession. They also noted that lesbian doctors were even more likely to experience higher rates of reported verbal harassment (43%) (180). This may also indicate anti-female attitudes on the part of some health professionals. Whether things have improved twenty years on remains to be confirmed. In a study of doctors' attitudes towards male homosexuality, not surprisingly gay doctors reported more positive attitudes towards male homosexuality (181).

In 2017, a survey by Stonewall (UK-based charity that represents the LGBT+ community) with over 5000 participants found that just under one-fifths had experienced negative comments from work colleagues (182). In addition, Stonewall's 'Unhealthy Attitudes 'report (183) found that 25% of LGBT+ health and social care staff had experienced bullying or abuse at work in the previous five years and 10% had witnessed colleagues express the belief that someone could be 'cured 'of being lesbian, gay or bisexual. These findings thus reflect structural bias.

Whilst no specific data are available on the experiences of LGB staff working in mental health services, given the higher prevalence of mental health problems amongst people from sexual minorities, one would hope that these settings might be more enlightened. In addition, affirmative

actions that visibly communicate an organisation's inclusive culture can ensure that staff from sexual minorities feel safe in the workplace and able to be open about their sexuality if they so wish. Stonewall publishes an annual workplace equality index - a benchmarking tool for employers to measure their progress on LGBT inclusion. However, in 2020, in the UK, only two healthcare organisations were included in the top 100, one of which was an NHS mental health service provider.

On a more positive note, workplace support groups for staff from sexual minorities are increasingly common in many mental health provider organisations in the UK and elsewhere (184). They provide peer support, networking opportunities and visible evidence of an inclusive workplace. Members are also often actively involved in ensuring the organisation's approach to diversity and equality (for both clients and staff) includes sexual minorities through membership of relevant committees and contributing to relevant policies.

These efforts can be helpfully supported by national professional organisations. For example, the American Psychiatric Association has included an Association of LGBTQ Psychiatrists since 1985 and in 2001, the UK Royal College of Psychiatrists set up a Special Interest Group on LGBT mental health (Rainbow SIG) that aims to include promoting the mental health of people from sexual minorities and supporting and advocating for LGBT mental health professionals (185). Sadly, it is still not uncommon for both these organisations to be contacted by psychiatrists who are struggling with the stress of working in an organisation where they do not feel safe to be open about their sexuality. This experience is probably common in most countries and no doubt much more needs to be done to tackle homophobia in the mental health workplace globally.

Recommendations

Having looked at the history of same-sex behaviours across different religions and geographical areas makes it obvious that attitudes do change according to various social factors. The evidence presented above suggests a number of key issues. Firstly , in many countries, there is no accurate data on number of individuals belonging to sexual minorities. Thus, blind application of findings from one culture to another are likely to be fraught with difficulties. The reasons for the absence of such data are well-recognised and are many . The most important factor is that as in a large number of countries, same-sex behaviour is illegal which means that acknowledging same sex orientation can lead to a number of unpleasant consequences including imprisonment or even death. Other reasons include unclarity about the use of certain terms or their acceptance in that particular society so that these are not included in population surveys and studies. This also affects a clear

understanding of the extent of incidence and prevalence of various psychiatric disorders in these populations who are not only underprivileged and vulnerable but are also understudied and often no acknowledgement made of their healthcare needs. This combined with stigma and discrimination against psychiatric illnesses can work as a double jeopardy and stop people from seeking help when they need it. Thus, there may be may also an under-reporting of psychiatric disorders in sexual minority groups. As there is clear evidence as has been discussed above, minority stress related to not-belonging has been identified as a clear factor in producing increased rates of psychiatric disorders in this population. It has also been shown convincingly that bringing about equality and equity in policies can lead to a reduction in the rates of psychiatric disorders in these sexual minorities. However, a majority of the studies and findings have been reported from high-income countries which may not be easily applied to low and middle-income countries. Cultural attitudes direct and drive acceptance of minority status. In many countries, negative attitudes towards same-sex behaviours and sexual minorities changed and became more negative as a result of colonization and religious influences and remain so in spite of activism to change these. Consequently, many cultures which used to be sex-positive cultures and were more accepting of same sex behaviour have subsequently become sex-negative. In countries like India in recent times, same-sex behaviour has been decriminalized but it remains a criminal act in a large number of countries.

In some instances medicine including psychiatry took over from religion and religious attitudes and followed these up with treatments with limited or no evidence. This in case of sexual minorities led to the use of so-called conversion therapies which have caused considerable damage to individuals, their families and society as a whole. Pathologisation of same-sex behaviour has led to not only stigmatizing individuals but has also often led to delays in help-seeking which can contribute to poor outcomes. National and international psychiatric organisations along with other stakeholders are in a powerful position to bring about changes in societies. Psychiatry's social contract has to be applied across the board so that all individuals in any given society have equal access to health services irrespective of their sexual orientation. All mental health professionals need cultural competence training to be aware of cultural challenges that sexual minority individuals face on a regular basis.

The recommendations made by the Commission are addressed to policymakers, clinicians and researchers but cross-sectionality of these three areas cannot be ignored.

Putting LGB Mental Health into policy

1. Policymakers should include impact assessment of each of their policies on LGB mental health. This is of particular interest related to foreign aid and countries around the globe.
2. Equity must be delivered in law and reality so that LGB individuals feel safe and respected which will help reduce rates of psychiatric disorders.
3. Suitable equitable funding should be made available for research, training and delivery of services.
4. All kinds of conversion therapies and clinics that aim or claim to change same sex attraction should be banned. Moreover, clinics and clinicians providing such therapies should be charged with human rights abuses.

Clinical services and clinicians

1. Therapists should receive training on the impact of self-disclosure, regarding both their clients' and their own sexual orientation; counselling and psychotherapy services should routinely monitor any discrepancy in satisfaction, access to treatment, engagement, and clinical outcomes for LGB people.

2. Psychotherapy training should include teaching on sexual minority development and cultures; psychotherapeutic practices that pathologise homosexuality should be replaced by more modern understandings of sexual orientation; therapists should be trained and supported to challenge their own biases in relation to clinical interactions with sexual minorities.

3.All health staff should have training in sexual minority cultural competence including the promotion of affirmative approaches such as the use of inclusive language as part of their mandatory diversity training.

4.Services should demonstrate their inclusiveness through visible means and in practice e.g. displaying affirmative posters in waiting areas, and profiling staff from sexual minorities on their website.

5.Workplace support groups for staff from sexual minorities in mental health provider organisations should be encouraged. They are needed not only to provide peer support but also networking

opportunities and visible evidence of an inclusive workplace. These networks can be extremely helpful in conveying suggestions to the boards of organisations and institutions.

6. All healthcare employees should be encouraged to become actively involved in ensuring the organisation's approach to diversity and equality (for both patients and staff) includes sexual minorities through representation of relevant committees and contributing to relevant policies. There should be possibilities for allies to come together and support minority groups.

7. Clinicians offering conversion therapies should be reported to their respective regulatory bodies and appropriate actions should be instigated.

8. These efforts can be helpfully supported by national professional organisations who must lead by example. These organisations can also help by creating and adopting position statements which are positive and affirming.

Research

1.Appropriate equitable funding must be made available for research into prevalence of various psychiatric disorders in sexual minorities.

2. Suitable funding should be made available by funding bodies to evaluate the effectiveness of therapy for sexual minorities and their mental health.

3.Special attention should be paid to include research into groups such as bisexual individuals and lesbians particularly in the global South. As has been shown rates of various psychiatric disorders are higher than accepted and a clear understanding of causes at social and political levels is needed.

4. Suitable equitable funding should be provided for research into the healthcare needs of LGB groups.

5. Researchers must be encouraged to use standardized definitions and inclusion of LGB groups in research studies.

6. Research tools to measure sexual orientation and identity need to be refined and universally agreed.

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