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## In This Issue:

### LGBTQ+ Health

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In 1952, homosexuality was classified as a sociopathic personality disorder. It was declassified as a mental illness in 1973, but discrimination was still rampant.

The first known HIV case was in 1959 in what is now the Democratic Republic of the Congo (DRC) and was called the Belgian Congo. Even the earliest names for the set of conditions were discriminatory—the prevalent name prior to 1982 was Gay-Related Immune Deficiency (GRID),[1] and it was not until 1982 that the CDC formally adopted the acronym AIDS, for Acquired Immune Deficiency Syndrome (check out this interactive timeline). By this time, around 300,000 HIV infections had already been recorded and over 10,000 individuals had died of AIDS.

The first US cases were detected in 1981; a New York Times article on July 3, 1981 noted "a rare cancer in 41 homosexuals"[2] (Kaposi's sarcoma). Misinformation about HIV transmission was rampant, and due to these and other factors, even some healthcare providers refused care for AIDS patients in the 1980s.[3]

Although we are better informed about the health care needs of the LGBTQ+ communities now, disparities still exist. Recent political and legislative changes at the federal level have introduced fear and uncertainty into the delivery of care for this population. It is worth mentioning the historic, critical role played by gay rights activists, such as those who founded the Gay Men's Health Crisis (GMHC) network in New York in 1982, and those who supported the Whitman-Walker Clinic in Washington, DC. Incidentally, WWC was supported by DC government funds at its inception, and was housed in a church basement for the first several years.

The Third Annual National Survey on the State of LGBTQ Health reports that fear of stigma and institutional distrust remain major barriers to care for LGBTQ+ communities, and threats to gender-affirming care are decreasing access for LGBTQ+ populations.[4] LGBTQ+ individuals are being diagnosed with depression and/or anxiety (90%), substance use (39%), gender dysphoria (36%) and suicidal ideation (35%) at alarming rates, and mental health issues are one of the three most significant barriers to LGBTQ+ patients accessing healthcare (19%).[4]

Fifty-one percent (51%) of LGBTQ+ service providers have considered leaving their jobs in the last six months, and the LGBTQ+ healthcare workforce is experiencing levels of burnout driven by political volatility, increased workloads, and unstable funding.[4]

As of May 2025, Delaware has 1,112 psychiatrists, 1,044 professional counselors of mental health, and 77 marriage and family therapists to provide services for 1.05 million Delawareans,[5] not to mention the bevy of institutions, providers, and resources illuminated in this issue of the Journal and beyond. Addressing the disparities in LGBTQ+ health care is crucial for achieving health equity in Delaware, and ensuring the well-being of these—and all—Delawareans.

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