

‘Homosexuality: are we adequately equipped to address this issue in clinical practice?’

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Lately, patients visiting clinicians have talked about their homosexual inclinations. Generally, they had problems of anxiety and depression and occasionally for distress associated with the sexual preferences. One young man, aged 21 mentioned that his heart starts beating faster when he heard a masculine voice. The same gentleman shared the information that many such individuals get acquainted with each other through the internet or common friends and meet in self designated parks located in various regions of Karachi. The activity goes on secretly owing to the stigma attached with this issue. There has been a lot of debate on the subject of homosexuality the world over. The major hue and cry is raised by professionals dealing with the menace of HIV where they state a prevalence of 31% in 2007 in Karachi.¹ According to a report, there can be 50,000 to 80,000 cases of AIDS in Pakistan.² The official number had increased to 85,000 by 2005.³ How much can this be attributed to homosexual practices is difficult to determine. In Pakistan, of the reported cases of HIV, there were seven times more men than women. Of the HIV-positive individuals 7% were homosexual men.³ The fear of getting infected with HIV is a major fear of these people. Besides, homosexuality is considered a taboo condemned by both legislature and religious teachings. Anecdotal reports and media releases do mention the rising trend of such practices. The matter becomes important when a medical practitioner is faced with the situation of dealing with such a patient.

There are different schools of thought about homosexuality. It is held by many scientists as pathology; others quote it as a psychopathology while genetic factors and childhood environment factors have also not been ruled out. Hormonal influence during intrauterine development is cited as a causative factor. Sigmund Freud believed that all human beings were innately bisexual and that they become hetero or homosexual as a result of their experiences with parents and others. According to him, homosexuality should not be viewed as a pathology.⁴ Other analysts argued that homosexuality resulted from pathological family relationships during the oedipal period (around 4-5 years of age); some others have mentioned that this was pre-oedipal and therefore even more pathological.⁴ Kinsey and his colleagues⁴ reported that 10% of the males in their sample and 2-6% of the females had been more or less exclusively homosexual in their behaviour for

at least three years between the ages of 16 and 55. In 1973, the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Later, a new diagnosis, "ego-dystonic homosexuality" was created. In 1986, the diagnosis was removed entirely from the DSM. The only category Sexual Disorders Not Otherwise Specified, which included persistent and marked distress about one's sexual orientation, remained in the manual.⁴ Apart from the risk of sexually transmitted diseases, homosexuals are vulnerable to a number of social complications. These include criminality, social disruption, behavioural problems, insecurity, addiction, suicide and emotional distress.⁵

In a New Zealand study,⁶ at the age of 21, homosexual/bisexuals were at fourfold increased risk for major depression and conduct disorder, five fold increased risk for nicotine dependence, two fold for other substance misuse or addiction and six times more likely to have attempted suicide. According to another study,⁷ gay men had a more than 3-fold increased risk of major depression and five fold risk of panic disorder. In a Vancouver study,⁸ life expectancy at age 20 years for gay and bisexual men was found to be 8 to 20 years less compared to other men. Regarding the social atrocities affecting mental health, a study⁹ of young homosexual men (18-27 years of age) in the US found that 37% of the respondents had experienced verbal harassment, 22% discrimination and 5% physical violence. High rates of attempted suicide have been documented among homosexual men compared to heterosexual men.¹⁰⁻¹²

In the National Co-morbidity Survey,¹³ the odds ratios were statistically significant for life time risk of suicidal thoughts among women and men and for lifetime risk and age at onset of suicide plans among women in the category of same-sex sexual partnership.

They are vulnerable to abuse, are subjected to greater mental distress and more likely to harm themselves.¹⁴ With the aforementioned situation especially in terms of associated mental health morbidity, the situation in clinical practice may be more serious. The stigma associated with homosexuality could prevent patients with other mental health issues to confide in their doctor. The general physician or psychiatrist may harbour bias and disapproval for such a problem which can impede a smooth consultation process. At times, the

practitioner's own sexual orientation can enter into conflict while dealing with such patients. Whether the patient wants to maintain the orientation or request for treatment is another question. Seeking treatment because of discrimination cannot be successful and could only aggravate the distress for the patient. Even when the patients presenting with psychiatric problems are treated, the core issue remains unresolved that could lead to multiple relapses over a time period.

There is little evidence about success in treatment for homosexuality especially for those who are exclusively homosexual. Empirical studies are not done on homosexuals in Pakistan though some literature is available about homosexuality and AIDS. How much are we trained to tackle this issue in clinical practice? Do we need special training? Are the psychiatrists aware of problem-specific psychotherapeutic approaches? These questions need to be answered.

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