Understanding the Homosexual Patient

The ultimate mistake in management is to see patients in terms of their homosexuality alone as this may be a minor aspect of their personality. The diversity among homosexual men and women is as great as that among heterosexuals

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It is important to emphasise the fact that there is probably no typical 'homosexual' patient any more than there is a typical 'heterosexual' patient. On the other hand, there are a number of aspects of homosexual life-styles which differ from many aspects of heterosexual life-styles. These are discussed in an attempt to clarify the appropriate medical and professional approach to homosexual individuals who may be patients.

It is equally important to note that until the last few years, sexual medicine courses were not available in medical schools with the result that medical practitioners have little, if any, knowledge about homosexuality over and above that held by the educated layperson. For this reason, it is important firstly to define homosexuality and to place it into a medical context.

The Homosexual-Heterosexual Continuum

Contrary to popular opinion, 'homosexuals' and 'heterosexuals' do not comprise 2 separate classes of people. Kinsey et al. noted that individuals fit into a continuum which has exclusive heterosexuality at one end and exclusive homosexuality at the other (fig. 1) [1]. If one considers that 1 in 3 male patients is likely to have had a homosexual experience leading to orgasm between the ages of 16 and 55 years, and that almost 1 in 5 will have had as much homosexual experience as heterosexual for at least a 3-year period in the same age range, then it is clear that the world cannot be divided into homosexuals and heterosexuals. However, because our society does stigmatise homosexual relations, we tend to divide individuals arbitrarily into 'homosexuals' and 'heterosexuals' and assume that these are absolute classes. In this article we define 'homosexual' as predominantly homosexual at a particular point in time.

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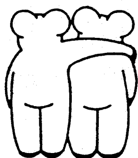


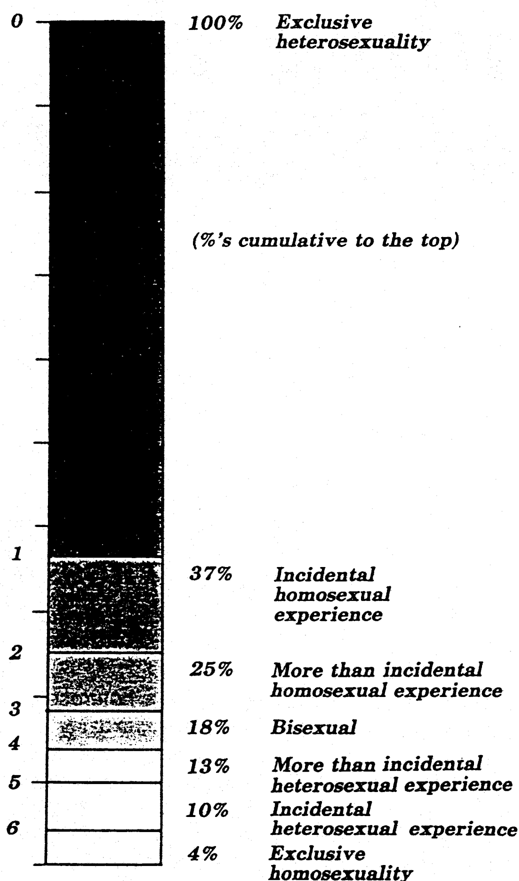


FIG. 1. Kinsey scale and associated proportions of male population.

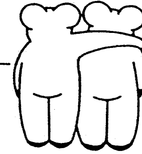
Homosexual preference may be primary, i.e. having sex is more important than who it is with, or secondary, i.e. the emotional attraction is to the same sex as well. Thus individuals may be behaviourally homosexual but not emotionally or vice versa. It is important to differentiate practice from preference. As an example, McConaghty et al. found in a sample of medical students that over 40% were aware of homosexual feelings, although presumably a much smaller percentage would have acted on these feelings [2]. Within so-called 'homosexual' male samples, Saghir and Robins found that over 48% had had sexual relations with a woman [3] which, as well as illustrating the lack of discrete groups, points to the fact that male homosexuality is not a distaste for female sexual partners but a preference for male ones.

Patients may tell the physician that they are homosexual for a variety of reasons

Disclosure and Medical Attitudes

Those patients who indicate to their medical practitioner that they are homosexual will do so for a variety of reasons, either because they wish to discuss the area with regard to sexual counselling [4] or because they believe that this information will aid medical management. However, not all overtly homosexual patients will share the fact of their sexual preference. Dardick and Grady found that less than 50% of openly homosexual men in the US had told their primary health-care provider that they were gay [5]. One must assume that for those who are covertly homosexual the figure is even lower. In Australia, I found that over 20% of gay men presenting with sexually transmitted diseases did not tell the attending practitioner that their infection was homosexually acquired [6]. Unfortunately, one of the reasons for this is that three-quarters of a sample of 1000 doctors acknowledged that knowing a male patient was homosexual would adversely affect their medical management [7]. As recently as 1980, 84% of American physicians surveyed agreed that homosexual patients hesitate to seek medical care because of physician disapproval [8].

In the light of these findings, it is important to realise that if a male patient volunteers information about his homosexuality the decision has probably not been taken lightly, and that an understanding and accepting response is important. It is also important not to assume that all patients are heterosexual unless one is advised to the contrary. Indeed, between 10 and 20% of gay men are or have been heterosexually married [9], and



some 54% of homosexual encounters in public conveniences are by married men who define themselves as heterosexual [10].

Areas of Difference in Homosexual Health Care

When a male patient has revealed his sexual orientation, this is usually in the interests of honesty and obtaining more complete health care. There is a tendency to see a homosexual preference as pertaining only to sexual matters, which is a particularly narrow definition. While this information may mean swabbing of additional sites for sexually transmitted diseases if the patient is sexually active (anorectal as well as the usual urethral and oropharyngeal sites), it also has farther reaching implications.

Stigma associated with homosexuality may present as psychological stress or psychosomatic illness

Since a homosexual preference is still stigmatised to a greater or lesser extent in Australasian society, the patient will carry burdens associated with either coping with negative reaction if he is overtly homosexual or, if he is not openly homosexual, coping with the anxieties of keeping sexual orientation hidden and fear of disclosure. The cost of this will be extremely variable. However, there are considerable implications in terms of psychosomatic illness including unexplained headaches, hypertension, gastrointestinal disorders ranging from ulceration to irritable bowel syndrome, and asthma which has a functional component. Psychological stress may also present in a variety of less somatic forms, such as sleep disturbance or generalised anxiety. In most cases the stress is manageable through an accepting clinical interaction or referral to stress management programmes and relaxation training.

On the other hand, the great majority of homosexual men will experience little or no problems with their sexual orientation. It is important to note that homosexuality has not been considered a mental disorder since it was removed from the Descriptive and Statistical Manual (DSM-3) of the American Psychiatric Association in 1973. Nor is there any evidence that, as a group, homosexuals are any different to heterosexuals in their psychological stability and mental functioning. Apart from difficulties with the same range of problems which trouble heterosexual individuals, the homosexual patient may be remarkable in psychological terms only where stigma management presents as an issue.

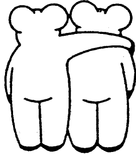
Stages of Acceptance of Homosexuality

Patients will present in different stages of acceptance of their homosexuality. The best model for describing the path to acceptance of one's sexual orientation has been described by Cass [11]. She has posited 6 stages in the development of a homosexual identity in the individual:

1. *Identity confusion*
2. *Identity comparison*
3. *Identity tolerance*
4. *Identity acceptance*
5. *Identity pride*
6. *Identity synthesis.*

Identity confusion describes the stage where individuals feel that they are different from others and that their feelings or behaviours may be labelled as homosexual. The second stage, identity comparison, is for the individual the first tentative commitment to a homosexual identity and the realisation of being homosexual to a degree.

With identity tolerance in the individual comes the recognition that he or she is probably homosexual and a degree of commitment to this identity arises. By stage four, the identity acceptance stage, the individual accepts the label of homosexual, at least in gay company, and begins to socialise within a gay subculture. The stage of identity pride is marked by wide disclosure and open activism and describes the situation where everything the individual does is defined primarily by his or her homosexuality. At this stage, the central identity of the person is as a homosexual.



The sixth stage of the Cass model is perhaps the one which has stimulated most debate. In the individual, the 'them versus us' view of homosexuals and heterosexuals fades, and is replaced by a situation where the person's homosexual identity is seen as being one of a series of identities, but not one which defines all aspects of the person's life-style. The individual may thus see being homosexual as an incidental matter like political belief or occupation, and not something that he or she is all the time.

Patients' sexuality must be dealt with depending on their own level of acceptance

It is important that we deal with patients' sexuality depending on the level of acceptance they are at and do not try to push them too fast through these stages. We should let them achieve these stages, with encouragement, at their own pace.

Homosexual Relationships

The popular view of the homosexual as promiscuous is not an accurate one for the great majority of gay individuals. A recent survey of gay men in the US found that the median number of lifetime sexual partners of sexually continuously active individuals was less than 50 [12]. It is important to bear this in mind when reading of atypical samples (e.g. many AIDS victims) in which numbers of sexual partners may number in the hundreds or thousands.

A significant proportion of gay men and women will be in homosexual relationships. These relationships have been classified into 4 general categories in a study of Californian homosexual men by Bell and Weinberg [13]. They divided their sample into:

1. *Close-coupleds*
2. *Open-coupleds*
3. *Functionals*
4. *Dysfunctionals.*

The 'close-coupleds' were closely bound together and monogamous, in the sense that the 2 individuals tended to look to one another for sexual and interpersonal satisfactions. They had the lowest level of sexual or psychological problems.

The 'open-coupleds' were living with a special sexual partner, but tended to seek sexual and interpersonal satisfactions with people outside their partnership although this tended to worry them. Psychologically and sexually, they had no more or no less problems than other groups.

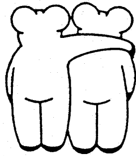
The 'functionals' were the equivalent of the swinging singles, and appeared to organise their life around their sexual experiences. They tended to have wide social circles and few sexual and psychological problems.

In contrast, the 'dysfunctionals' were troubled people whose life offered them little gratification and who displayed significantly greater psychological and sexual problems than any other group. This group most closely accorded with the old stereotype of the tormented homosexual.

While this sketch of homosexual relational patterns is brief, it does indicate the great diversity of interpersonal styles which exist within a homosexual life-style.

Sexual Practices and Sexually Transmitted Diseases

To most people, it is sexual practices and gender of partner which sets homosexuals apart from heterosexuals. In practice, however, the same range of sexual activities are practised by both heterosexuals and homosexuals, with the exception of the absence of penovaginal intercourse in homosexuals. It is not generally realised that anal receptive intercourse is practised regularly by 1 in 12 women [14]. While some homosexual men do have a preference for a particular role in anal intercourse or fellatio, the most common situation is for multiple sexual activities to occur in any sexual interaction. Contrary to popular opinion, anal intercourse only occurs in about one-third of male homosexual encounters. Fellatio and mutual masturbation are more common in terms of frequency [15]. In homosexual women, activities will most commonly involve oral or manual stimulation.



From a medical point of view, anal intercourse if carried out with inadequate lubrication or any great degree of vigour may lead to lesions of the rectal epithelium which in places may be only one cell thick, in contrast to the cornified vaginal epithelium. This may act as a portal for pathogens, and thus lead to greater risk than with penovaginal intercourse. The range of sexually transmitted diseases associated with homosexual men includes syphilis, gonorrhoea, non-gonococcal urethritis, hepatitis (A, B, and non-A, non-B), herpes, and the so-called 'gay bowel syndrome' including amoebiasis, giardiasis, shigellosis, Chlamydia infections, anal warts and proctitis [16].

Sexual attitudes affect life-style

While hepatitis and enteric infections are associated with analingus, a practice apparently much more common in the US than in Australasia, it is important to note that the spectrum of sexually transmitted diseases is markedly broader in sexually active homosexual men than was traditionally assumed. To these sexually transmitted diseases must now be added AIDS.

While the great majority of homosexual men will not be at any greater risk of sexually related infections, it is important to expand our previously narrow view of the range of sexually transmitted diseases and to test for additional pathogens in homosexually active men where symptoms occur. As an example, some 37% of Australasian homosexually active men may be surface antibody positive for hepatitis B [17].

Attitudes to Sexuality and Risk Factors in Homosexual Men

From a medical point of view, there are 3 major risk factors for sexually transmitted diseases in homosexual men:

1. *Partner numbers*
2. *Particular sexual practices, e.g. the risks of infection from mutual masturbation are negligible*
3. *Anonymity of partners, which makes contact-tracing difficult.*

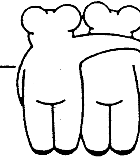
In a recent study of the psychological and social factors which influence sexually transmitted disease risks, I found that particular dimensions of sexual attitudes best predicted how the individual managed a homosexual life-style [15]. These dimensions included attitudes to relationships, degree of control of sexual excitement and libido, degree of being visually stimulated by members of the same gender, social comfôrt, acceptance of one's homosexuality, and degree of permissiveness or prudishness. Homosexual individuals may vary across all of these dimensions. It would be a mistake to assume that the simple fact of a homosexual preference can predict anything about how the individual exists as a homosexual. Again, it must also be emphasised that the range of attitudes in homosexual men and women is as wide as the range of attitudes in heterosexual men and women. However, those attitudinal dimensions referred to above do appear to be the important ones in determining what sort of sexual life-style is led.

Homosexual Women

Homosexual women are at much less risk than heterosexual women of contracting sexually transmitted diseases [18] and also enjoy on average much better mental health than heterosexual women [19]. They may still present with the usual range of medical problems as other women, although these are unlikely to be directly related to their sexual preference. Most if not all of the comments made with regard to male homosexuals will also apply to dealing with female homosexual patients, although some of the difficulties faced by homosexual women may include issues such as childrearing. There may also be difficulties with the management of social stigma.

Conclusion

In conclusion, while it is important to have a medical and psychological understanding of the range of problems which homosexual men and women may have, it is also critical that we see these health problems as being neither solely sexually related nor stereotypically homosexual. In understanding and managing homosexual patients, the central issue is to appreciate that



homosexual individuals cover the same wide spectrum of humanity as heterosexual persons, and that the division of people into 'heterosexual' and 'homosexual' groups is arbitrary although less psychologically threatening. The ultimate management mistake is to see patients in terms of their homosexuality alone and to ignore the fact that their sexual orientation may be a minor aspect of their identity and personality. The diversity of individuals who may be homosexual precludes generalisation about them from the fact of their sexual orientation alone.

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