Homosexuality

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Introduction, Definitions, and Key Concepts

Homosexuality is not a medical or psychiatric disorder but is a state associated with an increased risk of certain medical conditions. Homosexuality has long been recognized both in human and animal populations. Despite the relative frequency of homosexuality, it remains misunderstood and controversial to much of society. Homosexual individuals who choose members of their own sex for sexual relations and domestic partnerships are often targets of prejudice and may even be discriminated against by health care professionals.

The psychiatric and biologic literature on homosexuality has grown rapidly over the past 30 years. The literature now provides both a biologic and behavioral perspective on homosexuality and guidance on how physicians can positively affect the health of their gay and lesbian patients. Physicians who understand current scientific views of homosexuality are in a position to provide excellent care to gay and lesbian patients and to provide a model of leadership in their communities and hospitals regarding issues of homosexuality. Without such understanding, physicians risk repeating the prejudicial and harmful actions that often characterized medical treatment of gay and lesbian individuals in the past. This article provides an overview of homosexuality and is intended as a basic guide for both psychiatrists and general physicians.

Information regarding homosexuality is spread widely across the disciplines of psychiatry, psychology, general medicine, neuroscience, sociology, genetics, and anthropology. Thus, nonspecialists have difficulty in finding and evaluating the science and literature that are now available. The American Psychiatric Association recognized the need for a comprehensive reference that would make the literature accessible to generalists and specialists alike. The resultant *Textbook of Homosexuality and Mental Health* remains the single best reference for psychiatrists and general physicians to find information on homosexuality.[1]

A brief review of definitions and key concepts may be helpful. The term gender identity refers to an individual's internal sense of being male or female, boy or girl, man or woman. According to ego psychology, gender identity develops early in childhood and normally solidifies by age 2.5 years.[2] Most homosexual individuals have a firmly established gender identity that is consistent with their anatomy. For example, a homosexual man understands himself to be a man, just as does a heterosexual man. When gender identity is not firmly established, an individual may experience significant psychological distress, which is termed gender dysphoria.

The term gender orientation refers to an individual's desires and preferences regarding the sex of intimate partners.[3] Like gender identity, gender orientation is based on deeply held conscious and unconscious psychological constructs.[4] As Kinsey and others have shown, gender orientation is more of a dimension than a category.[5,6] That is, individuals tend to have a range of preferences and desires rather than falling into neat, mutually exclusive categories.[7]

Who is homosexual? On the level of individual psychology, most adults experience themselves, and identify themselves to others, as either heterosexual or homosexual, despite the well-recognized fluidity of human sexual orientation. A smaller number of adults experience themselves as having relatively little preference for one sex over the other, and they identify themselves as bisexual. The terms gay and lesbian have been adopted by a large number of self-identified homosexual individuals as preferred ways of referring to their gender orientation as well as to the culture they have developed as an alternative to mainstream straight (ie, heterosexual) culture.

On the societal level in the United States, little tolerance exists for the varying expressions of sexual orientation, and the need to identify individuals as being either heterosexual or homosexual tends to be imperative. For example, many military, religious, educational, and voluntary organizations often demonstrate intense interest in whether one of their members is or is not homosexual, and they determine ways to deal with the individual once this label has been applied.[8,9] The intent is usually to expel, or in some way marginalize, the homosexual individual.

Gradations of sexual orientation are given little importance, and the notion that evidence of any same-sex–oriented behavior indicates that an individual is homosexual is often given credence. This forced choice into rigid, predetermined categories is a custom that has clear parallels in racist attitudes and practices. For example, individuals have been categorized as either colored or white, with the stigmatized colored status conferred on people of mixed heritage even when most of their relatives were white.

Interestingly, in important social institutions, primarily in the arts, sexual orientation appears to be more fluid, orientation categories less clearly defined, and discriminatory practices much less of an issue. In fact, certain entertainers have found commercial advantage in cultivating an image of ambiguous sexual identity and orientation. A more straightforward expression of a homosexual identity may still lead to controversy and potential career problems for mainstream entertainers.

Further complicating the picture is the fact that identity, orientation, behavior, and attraction may be expressed in ways that integrate seemingly contradictory elements. For example, some individuals who think of themselves as heterosexual engage in homosexual behaviors, and vice versa.

Other dimensions of partner choice may be given weight along with gender and, at times, may be of more importance. Individuals may prefer a more or a less active sexual role; younger or older partners; one or another physical focus of erotic feeling; one or another erotic activity; exclusive or nonexclusive partners; sexuality integrated with other elements of relationships or sexuality devoid of personal relationships; extended, nuclear, or other family configurations; and lifestyles that range from traditional modes to unconventional arrangements. In short, sexuality comes in more variations than individuals and society commonly recognize.

Thus, we describe sexual orientation in behavioral terms, designating men who have sex with men (MSM) and women who have sex with women (WSW). One often observed pattern is that of a married, apparently heterosexual male who also has sex with men under certain circumstances. This may be an important factor to the primary care physician assessing STD risk in a particular patient. The CDC currently recommends universal HIV testing for everyone aged 13-69 years so that the full details of a patient's sexuality need not be revealed for good preventive care to take place in the primary care office.

Again, importantly, homosexuality is not a psychiatric disorder. In this section, the authors briefly review psychiatric disorders that involve elements of sexuality and that could be confused with homosexuality. The purpose of this discussion is to differentiate these disorders from homosexuality and to refer readers to other eMedicine articles for further discussion.

Gender identity disorder

Gender identity disorder (also known as transsexualism) is a condition in which a person has strong and persistent cross-gender identification as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (*DSM-IV-TR*).[10] That is, the person experiences feelings that he or she is, or should be, the other sex. These feelings are of sufficient intensity to cause clinically significant distress or social impairment. The disorder occurs in males and females and is independent of sexual orientation. The status of this disorder is in flux. Sex change through sexual reassignment surgery, hormonal treatment, and lifestyle change are options favored by some individuals.

Other transsexuals argue for the recognition of transsexualism as nonpathological, just as homosexuality is now recognized as nonpathological. These individuals assert that transsexuals face distress due to a lack of social acceptance rather than because of an intrinsic psychiatric disorder. Clearly, individuals with severe disturbances of

gender identity face marked difficulties with social acceptance, and this reality must be acknowledged. The individual's point of view should be explored and recognized as a guiding force for treatment. Treatment should be designed to reduce suffering and to improve social function in ways that respect and validate the individual's beliefs, desires, values, and sexual politics.

For additional information, refer to the eMedicine article Sexual and Gender Identity Disorders.

Sexual dysfunction

Sexual dysfunction, as defined by the *DSM-IV-TR,* comprises a group of disorders related to the disturbances in the sexual response cycle. Four phases of the sexual response cycle are recognized: desire, excitement, orgasm, and resolution. In this context, desire refers to the degree of interest in sexual activity, not to gender orientation. Disturbances of the other phases involve problems performing sexual acts or pain during sexual activity. These disorders apply to men and women without regard to sexual orientation.

For additional information, refer to the eMedicine articles Erectile Dysfunction and Sexuality and Disability.

Paraphilia

Paraphilias are sexual disorders that occur in both heterosexual and homosexual individuals, and they are often associated with personality disorder.[10] These disorders involve intense, recurrent sexual urges or behaviors that involve nonhuman objects, cause pain or suffering to the individual or the sex partner, or involve harmful sexual contact with nonconsenting children or adults.

For additional information, refer to the eMedicine article Paraphilias.

Epidemiology

The prevalence, incidence, and acquisition patterns of homosexuality have been studied extensively.[11][12] Despite these studies, truly reliable data regarding the epidemiology of homosexuality are few because of 2 methodological hurdles. The first involves the definition of homosexuality. Since a firm demarcation between homosexual and heterosexual individuals does not exist, surveys differ in the characteristics of individuals considered to be homosexual. The second, and perhaps insurmountable, obstacle is the reluctance of many individuals to disclose information about their sexual orientation because of the realistic fear that disclosure could be damaging to them.[13] Thus, incidence and prevalence parameters of sexual practice and orientation cannot be defined in the same sense or within the same confidence intervals that have been ascertained for psychiatric disorders through studies such as the Epidemiological Catchment Area Program.[14]

Methodologically weak estimates of the number and distribution of homosexual people have been in the literature for decades, placing the lifetime population prevalence of homosexuality at around 10%. Estimates are based largely on Kinsey's pioneering surveys of preferred sexual practices. The problem with such estimates is that they are based on reports of selected and self-selected informants rather than on random samples of the population. The results of such studies are useful for within-subject correlations rather than for population parameters.

Kinsey's studies contributed an understanding of the dimensional nature of homosexuality by scaling heterosexual and homosexual experiences and reactions on a 0-to-6 scale, ranging from exclusively heterosexual to exclusively homosexual. He found that men and women in his nonrandom samples were distributed from 0 to 6 with a sizable minority having both homosexual and heterosexual experience and a small minority being exclusively homosexual.

More recent studies have sought to describe the population more carefully. The National Health and Social Life Survey (NHSLS) of 1992 used a multidimensional framework of behavior, desire, and identification.[15] About 10% of men and 5% of women had homosexual contact since puberty, and 5% and 4%, respectively, had homosexual contact since age 18 years. The validity of these numbers has been questioned owing to the weakness of the sampling methods. Perhaps the most important contribution of the NHSLS is its resounding confirmation of Kinsey's findings that sexual orientation is complex and dimensional, with no clear distinction between homosexual and heterosexual persons. In a

study of 6399 British women aged 16-44 years reflecting data gathered from both face-to-face interviews and computer-assisted self-interviewing from 1999-2001, Mercer et al found the prevalence of WSW was 4.9%.[12]

The 2000 US Census has provided significant new information regarding the composition of households in the United States.[16] While intimate details of sexual behavior obviously are not matters divulged to census takers, the Census obtained reliable data regarding the sex and relationship composition of households across the United States. The Census sample size and known denominators allow for a dependable estimate of population prevalence of several dimensions of gender relationships.

The Census indicates that at least 500,000 same-sex couple households exist, with this number expected to increase by 10-20% when outstanding reports from 8 states are completed. About 0.5% of the US population appears to be living in same-sex couple relationships. Additional numbers live as singles. Even more have had lifetime experiences that qualify them as homosexual by NHSLS criteria. The most important conclusion from the US Census may be that homosexual people are sufficiently numerous in the United States that any medical practice or health care institution serving the public must take homosexuality into account when planning and delivering health care.

Etiology

The phenomenon of homosexuality is complex, as are its origins. As with epidemiology, the etiological study of homosexuality is hampered by a lack of clear definitions of homosexuality as well as the substantial overlap between heterosexuality and homosexuality. Serious discussion of the etiology of homosexuality is often derailed as simplified notions are used to support one or another political view regarding homosexuality.[17] The familiar biopsychosocial model is a useful way of organizing what is known regarding the causes of homosexuality.

Biological factors

Evolutionary theory is perhaps the most basic level of biological thought. Evolutionists have struggled with the question of why homosexuality is an entrenched element of human behavior. Taken at face value, an intense selective pressure against homosexuality seems to exist since homosexual individuals almost surely have fewer offspring than heterosexuals. A current response to this conundrum is that human populations with homosexual members may have unique group survival characteristics that preserve the presence of homosexuality.[18,19] The survival advantage may come from having extra workers in the group, which allows for better care of children. Clearly, all evolutionary theory regarding homosexuality is purely speculative.

Same-sex domestic and sexual relationships are a phenomenon found not only in humans but also in animals. Intensive studies involving several animal models (eg, birds, sheep, macaques) have also shown same-sex domestic and sexual relationships. Researchers studying bird pairings have noted that same-sex pairings occur in monogamous species and are related to social mating systems. For example, female same-sex mating is more frequent when the degree of polygamy increases, whereas male same-sex mating decreases as polygamy increases.

Studies have shown that 8-10% of rams are male-oriented in partner selection.[20,21] Comparative studies of female-oriented and male-oriented rams have not identified social factors to explain the dichotomy. Examination of the brains of the 2 ram subgroups (ie, female-oriented rams, male-oriented rams) indicates that female-oriented rams have a larger ovine sexually dimorphic nucleus (oSDN) in the preoptic area-anterior hypothalamus than do male-oriented rams. The hypothalamic morphology has also been studied in same-sex–oriented female Japanese macaques.[22] Because the anterior hypothalamic nucleus (AHdc) varies in size between the macaque sexes, with the male having a larger nucleus, the female-oriented macaques were thought to have a more malelike brain structure. This idea was not supported by initial studies, which found that same-sex–oriented female macaques had a grossly female hypothalamus. Perkins and Roselli note that adult sexual behavior in rams results from permanentorganizational effects of testosterone on brain development. They believe that male-oriented ram behavior may be a consequence of individual variations in brain sexual differentiation.[21]

The maternal immunization theory of homosexuality postulates that sexual orientation is more likely to be male-oriented in men with older brothers. The theory also holds that the likelihood of homosexuality increases with the

actual number of older brothers. The concept suggests that maternal immunization occurs to fetal y-linked minor histocompatibility antigens and increases with each succeeding male fetus.[23]

The biologic basis of physical attraction based on pheromones or odor chemosignals is well understood in many species. In humans, odor signals are often subtle and unconscious given the relatively minor role of odor-based conscious communication. Nonetheless, human odor signals play a significant role in human behavior.[24] A recent study analyzed pheromone-based attraction and repulsion among heterosexual individuals and gay individuals based on human body odor samples.[25]

In a study design that forced choices, gay male odors were least preferred by all groups except that of gay males, who preferred the odors of gay males and heterosexual females. Both heterosexual females and lesbians preferred odors from heterosexual individuals of either sex to odors from gay males and lesbians. Heterosexual males preferred the odors of heterosexual males and females; they least preferred the odor of gay males. Research has already shown a possible relationship between major histocompatibility groups and sexual orientation; axillary pheromones may be linked to this biologic basis of sexual orientation.[26]

Prenatal hormonal and chemical influences have been studied as potential contributors to the expression of same-sex orientation. Increased spatial abilities have been associated with prenatal androgen exposure in previous studies. A recent study showed a strong correlation between nonheterosexual (ie, heteroflexible) behavior and spatial abilities in premenopausal women, implying an association between heteroflexible sexual preference and prenatal androgen exposure. Another study of prenatal influences demonstrates a higher rate of female homosexuality among offspring of mothers who took amphetamine-based diet pills or synthetic thyroid preparations during pregnancy.[27] Nicotine exposure during pregnancy has also been suggested to contribute to the development of female homosexuality among offspring in animal models.[28] Meek et al studied mice who were stressed with light, heat, noise, and handling during the last week of pregnancy and found that the resultant male offspring showed a preference for male sexual partners.[29]

While physiological explanations for homosexuality have been sought, no definite findings exist.[30] Genetic factors may play a role, but the evidence is far from conclusive. No clear patterns of inheritance exist.[31] The standard genetic methods have been applied, including pedigree analysis, twin studies, adoptee studies, and molecular genetic linkage studies.

Twin studies show a higher concordance for homosexuality among homozygous twins (identical twins) than among heterozygous twins (fraternal twins). Among identical twins, concordance rates for homosexuality are reported in the range of 48-66%, which indicates that genetic factors most likely play a role but are not the only factors in the expression of homosexuality. Molecular linkage studies have suggested chromosomal regions that may be involved in conferring a susceptibility to homosexuality (eg, Xq28), but a specific gene has not yet been identified.

The hormonal environment in which a fetus develops clearly influences sexual anatomy and may influence behavior. For example, prenatal androgens are required for the development of male external genitalia in genetically male fetuses. In animals, a number of clearly described behavioral consequences of intrauterine hormonal manipulations exist.[32] For example, female rats exposed to increased androgens during fetal development show increased male-type mounting behavior as adults. The relevance of such findings to human behavior is unclear.

Presumably, genetic, hormonal, and other biological factors influence behavior by affecting the structure and function of the brain.[30] In rodents, observable differences in brain morphology are related to fetal hormone exposure that correlates with later behavior. Such clear differences have not been demonstrated in humans. Human brain regions putatively involved in homosexuality include the interstitial nuclei of the anterior hypothalamus (designated INAH1, INAH2, INAH3, and INAH4), the supraoptic nucleus, the anterior commissure, and the corpus callosum. Findings vary among studies. No consensus exists regarding what constitutes the human "homosexual brain," and no evidence supports the notion that one exists.

At the very least, biological factors influence variations in fundamental cognitive and emotional processes, which together determine temperament, intensity of sexual urges, desire for nurture versus adventurousness, and the like.

These characteristics influence how an individual reacts to social opportunities and could influence choices. At most, gender orientation is profoundly influenced by biological factors. At this point, data are simply insufficient to know how much of the variance in gender orientation should be credited to biological factors.

Psychological factors

By early adolescence, most individuals have a fairly well-defined inner sense of gender orientation; however, expression of their sexuality is highly influenced by the sexual behavior that they observe around them and the opportunities that present themselves. The NHSLS data, among others, suggest that experimentation with various options for sexual expression peaks during adolescence. This may be thought of as individuals trying out various possibilities to find what fits them best. Throughout normal adolescent development, the individual forms an increasingly coherent sense of personal identity. As this sense of self solidifies, patterns of partner choice, sexual behavior, interpersonal commitments, and lifestyle also become more consistent.

Psychoanalytic theories deal with the acquisition of sexual desire and identity.[33,34] Object relations theory and self-psychology deal with the creation of an identity out of family interaction and other experiences. Psychoanalytic theories based on Freud and found scattered throughout his writings point to various etiologies within the family for origins of homosexuality.[35]

Freud termed *homosexuality inversion* and was undecided on the issue of whether it represented a form of psychopathology. Noting that most homosexual individuals had no other significant abnormalities and led productive lives, Freud was one of the first to view homosexuality as a normal variant rather than a disorder. Freud held that all humans are bisexual in nature. He wrote that homosexuality was part of normal development and that all children experience a homosexual phase.[36] He described a number of possible variations in the oedipal and pre-oedipal periods — all forms of arrested development — which could result in a homosexual outcome. For example, excessive attachment to his own phallus in the autoerotic phase was seen to be the basis for rejection of a future female sex object when he discovered that she had no phallus.

Later, Freud suggested an alternative pathway in those boys with overly intense attachments to their mothers. In these cases, denied direct sexual gratification, the boys regressed to an earlier stage, identifying with the object denied them (ie, their mothers). They went on to seek the objects that their mothers might choose and were attracted to young men instead of women. This mechanism of homosexual development was further developed by Bieber, who surveyed nuclear families of homosexual men and found a greater incidence of dominating and overly familiar mothers and weak and hostile fathers than in families of heterosexual men.

Social perspectives

While biological factors may influence preferences, the social environment largely determines what choices are available. Anthropological studies demonstrate that, in some societies, homosexual behavior has been an accepted aspect of everyday life, but in other societies, homosexual behavior has been seen as a highly deviant act punishable by death.[37] Thus, unsurprisingly, the expression of homosexuality varies with social context.

Within Western society, pressure exists to publicly identify oneself in terms of sexual identity. Individuals are expected to have an identity and to disclose their identity to others. At times, an identity is thrust upon individuals by their social group before the individual comes to his or her own formulation of identity.

When individuals opt for a homosexual social identity, they often go through a social ritual called coming out.[38,39] The process of coming out begins with recognition of one's sexual identity, passes through consolidation of identity, and ends with social declaration of being homosexual. Like many social passages, the coming-out process can proceed as a smooth transition or it can be cognitively and emotionally complicated, disruptive of family alliances, and socially turbulent. Coming out is by no means required for identity formation but is becoming the norm for today’s gay high schoolers. In 2008, relatively little stigma is attached to the coming out process in the United States. Despite more accepting societal attitudes, some individuals with a firmly established homosexual identity choose to hide this identity to avoid any possible censure, often referred to as being in the closet.

Psychiatric Perspectives

The status of homosexuality in psychiatric theory and practice has undergone a remarkable transformation in the past 35 years.[40] For much of the 20th century, homosexuality was regarded as a personality defect, a symptom of psychiatric illness, or a psychiatric illness in its own right. In the early 1970s, homosexuality was removed from the American Psychiatric Association's list of mental disorders with the recognition that homosexuality in and of itself is not pathologic. That point of view has continued to the present and has gathered strength through the years. As with almost every issue in psychiatry, a minority opinion exists. Some psychiatric theorists continue to assert the pathology of homosexuality, but they are well outside the mainstream of contemporary psychiatric theory.

Historical perspective

Before 1970, most psychiatrists adhered to the common wisdom of the day: homosexuality was immoral and an indication of some sort of defect in the individual.[41] Sigmund Freud took a somewhat more benign position, viewing homosexuality as an indication of arrested psychological development.[42] Apparently, he did not view the developmental arrest as being of great import because he thought that homosexual individuals were suitable psychoanalysts. Other psychoanalysts viewed homosexuality as an indication of much deeper pathology.[43]

Based on opinions such as these, treatments were designed to cure homosexuality. Psychoanalysis and similar psychotherapies were undertaken to repair the presumed intrapsychic pathology. With the rise of behaviorism based on the work of Skinner, behavioral treatments for homosexuality competed with psychoanalysis.[44,45,46] At times, individuals did indeed seem to change their orientation or behavior, which is not unexpected given the range of individuals who were treated. For individuals with firmly established homosexual identities, however, a supposed cure was rare. Some authors and therapists continue along these lines.[47] At this point, such treatments must be viewed, at best, as well-intentioned but misguided efforts that should certainly not be repeated.[17] Bizarre surgical and hormonal approaches have also been attempted, but these approaches have no standing in modern medicine or psychiatry.

By the 1970s, recognition was growing that homosexuality was not inherently pathological and that treatment of homosexuality per se made little sense. The current era of understanding of homosexuality can be considered to have started in 1973, when the American Psychiatric Association dropped its pathologic designation of homosexuality. Interestingly, although homosexuality is no longer considered abnormal by the US psychiatric community, 49% of Canadian citizens view homosexuality as an abnormal condition.[48]

Current perspectives

Although homosexuality is not a psychiatric disorder, psychiatrists have much to contribute to the emotional well-being of homosexual individuals. Like everyone else, homosexual individuals may develop any psychiatric disorder. In addition, homosexual individuals may have adjustment, personal, or relationship issues that are directly related to being homosexual. At times, posttraumatic stress issues occur because of victimization related to the person's status as homosexual.

Much attention has been paid to the association of homosexuality, psychopathology, and suicidality. Two epidemiological studies have focused on this issue.[49,50] The result has been continuing controversy regarding the exact meanings of these studies and the etiological factors that explain the findings.[51,52] Nonetheless, "homosexual people are at a substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder ".[53]

The increased risk for suicide seems to exist mainly among homosexual males younger than 30 years. As noted previously, while the rate of suicide is substantially higher for gay youth than for heterosexual youth, the great majority of homosexual youth do not exhibit suicidal behavior. In 2004, a scientific study in the United Kingdom indicated that, of those sampled, 43% of gay men and lesbians had a mental disorder and that 31% of the total sample group had attempted suicide. While care must be taken not to regard homosexuality as a psychiatric disorder, care must also be taken to recognize and treat psychopathological conditions that arise in homosexual individuals.

To effectively treat homosexual individuals, psychiatrists need a basic understanding of homosexuality and homosexual culture and a degree of freedom from emotional reactions to homosexuality sufficient to interact with patients in a compassionate yet professional manner. As with all patients, psychiatrists must be able to listen to the homosexual patient and to understand the patient in terms of culture, values, and phase of life.

A number of psychotherapeutic issues are likely to arise in treating homosexual individuals. For adolescents and young adults, issues of gender identity may be prominent. Patients may be struggling to develop an authentic identity. Supportive and exploratory psychotherapy may allow the patient to develop a cohesive, durable sense of self and authentic gender orientation. For young adults who are coming out, relationships within the family of origin may be strained or difficult, and family therapy may be useful.

Homosexual individuals may experience occasional adjustment disorders as a result of chronic stress due to living with social stigma or to acute victimization (eg, being attacked for being gay). Discrimination from society still occurs. Same-sex–oriented youth seem to be more likely to experience violence than heterosexual youth.[54]In addition, individuals may carry negative images of themselves, and they may need to overcome their own shame and negative attitudes toward homosexuality.[55]

A recent study indicates that gay teens are twice as likely to contemplate or commit suicide compared with heterosexual teens; however, the same study found that 85% of same-sex–oriented youth never contemplate taking their own lives.[56]Another study noted that gay, lesbian, and bisexual youths are at greater risk of mental health problems, sexual risk-taking behaviors, and decreased general health maintenance than their heterosexual peers.[57]Mercer et al report that bisexual women have a greater number of male sex partners, more unsafe sex, smoking, alcohol consumption, IV drug use, and an increased rate of induced abortion and STDs compared with heterosexual women.[12]

As with heterosexual couples, gay and lesbian couples may have relationship difficulties. Couples therapy, or family therapy if the couple has children, may be useful. Generally, couples therapy for gay couples is similar to that for heterosexual couples, and treatment focuses on developing clear communication, exploration of values, expectations within the relationship, and issues related to developing as individuals as well as partners.[58]Despite these similarities, gay and lesbian relationships have aspects that differ from heterosexual relationships. See Gay and Lesbian Couples: Relationships and Sexual Practices for specific information about gay and lesbian couples.

Social Aspects of Homosexuality

Homosexuality is as much a social phenomenon as an individual one. This section deals with the historical and cross-cultural aspects of homosexuality and with the place of homosexuality in contemporary Western society.

In the United States, homosexuality continues to be a matter of considerable controversy. Many individuals and groups oppose homosexuality on moral and religious grounds. Gays and lesbians remain marginalized and are subject to discrimination. The concept of homophobia has been used to explain much of the negativity that surrounds homosexuality. Nonetheless, society is responding to the legitimate needs of gays and lesbians in a number of important ways. Homosexuality is now very much a part of mainstream American society.

Historical and cross-cultural perspectives

Given the diversity of human culture, homosexuality has not surprisingly been expressed in a wide variety of forms and has been regarded in sharply contrasting ways across different historical periods and in different societies.[37]In some times and places, homosexuality has been an accepted element of everyday life. In other contexts, it has been considered a moral offense punishable by death. In yet other contexts, it has been designated as a pitiable anomaly to be cured by medical treatment. Cultural anthropologists have developed elaborate systems to characterize the social structures and functions associated with homosexuality within particular societies.

Perhaps the best-known historical example of a society that regarded homosexuality in a positive way is that of ancient Greece. In the ancient Greek city-states, male and female homosexuality was a socially approved and institutionalized

practice associated with military, educational, and religious institutions. Such activity did not interfere with heterosexual marriage and parenthood. Recent scholarly attention has been given to socially accepted homosexuality within some traditional Native American cultures.[59] Less well-known examples are various socially accepted homosexual practices in developing or traditional societies.[60]

Discrimination and homophobia

Social stigma and discrimination against homosexual individuals remain active in contemporary Western society, yet these forces are diminishing as homosexual couples become more mainstream through marriage, civil unions, and ever-increasing social honesty. Remaining bastions of discrimination include the military[9], despite the "don't ask, don't tell" policy, and the Boy Scouts of America[61]. At its worst, antipathy toward homosexual individuals still results in outright attacks and hate crimes[62], such as the nationally publicized murder of a young gay man in Montana in 1998.[63]

The concept of homophobia was developed in the 1970s to explain societal prejudice against homosexual individuals.[64,65,66] According to this paradigm, people feel anxious or uncomfortable dealing with issues regarding homosexuality or when dealing with homosexual people. They manage this discomfort by avoiding contact with issues and with homosexual people. This behavior becomes entrenched because it effectively eliminates the discomfort. This behavior is so prevalent, however, that homosexual individuals are marginalized from society. Homophobia is also used to describe negative feelings and self-loathing among homosexual people, which hold them back from appropriate assertion of nondiscriminatory treatment in society.

Emerging opportunities

Many developments indicate that society is becoming more broadminded concerning homosexuality. Several advocacy organizations, such as Amnesty International[67] and the American Civil Liberties Union[68], are working to improve the legal rights of homosexual individuals. Current issues include extension of health insurance benefits to homosexual partners and children of homosexual couples, expansion of antidiscrimination laws to include discrimination based on gender orientation, and extension same-sex marriage, which, in the United States, is currently legal only in Massachusetts.

Change is also occurring because the business community has recognized the buying power of gays and lesbians. Businesses ranging from vacation resorts to investment houses are tailoring their services and marketing to focus on the gay population and are known as "gay-friendly." Advertisers are beginning to favorably portray homosexual couples and families with children. Many cruises cater to gay clientele and 20% of gay men and lesbians have taken part in a cruise within the past year.[69]

Confined populations

Within prisons, forms of same-sex behavior emerge that are distinct from the homosexuality that occurs outside of prisons.[70,71] Young men in prison are vulnerable to homosexual rape and domination by older inmates who are powerful within the inmate social structure. Young men who appear weak, effeminate, or gay are at the highest risk of being victimized. The men who do the victimizing regard themselves as heterosexual, and other prisoners also regard the victimizers as heterosexual. These relationships are coerced, and the young man acting in this role hopes to gain protection from other prisoners. Such behavior has little to do with homosexuality per se and is better understood as a distinct social phenomenon that occurs because of the lack of heterosexual partners and the unrestrained power politics of the prison yard. Physicians who care for prisoners must be aware of this phenomenon.

Gay and Lesbian Couples: Relationships and Sexual Practices

Couples of any sexual orientation are formed to satisfy some or all of the following needs: food, shelter, safety, sexual expression, procreation, companionship, social status, achievement, love and affection, and self-fulfillment. The nature and degree of commitment to the relationship varies from couple to couple. Homosexual relationships, like heterosexual relationships, are diverse. They may or may not involve cohabitation or exclusivity or be exclusive of

formal or informal heterosexual involvement. Homosexual relationships may be lifelong, short-term, serial, or in-between. The defining characteristic of homosexual relationships is that the individuals identify themselves as a couple. Some couples formalize the relationship through religious or secular ceremonies or through marriage or civil unions where available.

Homosexual couples who live together as a married couple are achieving a recognized domestic status, as reflected in the coding for the 2000 US Census. Legal institutions are being created to formalize and recognize homosexual relationships, providing them with the protections and accommodations allowed to heterosexual couples in both married and living-together-as-married statuses. Several states offer civil unions for gay couples, and Massachusetts offers marriage for gay couples. New York state, while not offering gay marriage, recognizes marriages between same-sex couples which have been legalized in Massachusetts. Rhode Island, on the other hand, does not have a mechanism for divorce of gay couples married in Massachusetts because it does not recognize gay marriages legalized in other states. In the November 2004 election in the United States, 11 states had anti–gay-marriage amendments to their constitutions on their ballots; all 11 amendments passed. Most Americans continue to oppose gay marriage but favor civil rights for gay men and lesbians.

The homosexual couple begins with some unique opportunities.[72,73,74] While men and women in heterosexual relationships have some latitude in their acceptance of normative gender-specific identities and behaviors, members of homosexual relationships may actually make more conscious choices of independence, competitiveness, emotional distance, exploration, nurturing, relationship maintenance, vulnerability expression, and other couple-related attributes. At least in contemporary Western societies, homosexual couples are more likely to make explicit choices regarding the amount and quality of contact allowed with other individuals, etiquette, division of labor, and lifestyles. In addition, the homosexual couple, more than others, develops a strategy and set of tactics for dealing with an outside world that can be barren, hostile, and hazardous as well as possessing opportunity, support, and protection.

Although each homosexual couple is unique, some generalizations apply and are a useful starting point in evaluating specific couples.[58] Not surprisingly, gay couples and lesbian couples differ from each other in characteristic ways, with gay couples displaying more traditional male behaviors and lesbian couples displaying more characteristics associated with women in other contexts.

Compared to lesbian couples, gays tend to place a greater emphasis on genital contact, more frequent sexual activity, looser connections among sexuality and emotional involvement and intimacy, less exclusivity in relationships, greater preference for autonomy, and more exploratory inclinations. Early studies of male homosexual relationships focused on uncommitted recreation rather than on intimate, lasting relationships. Homosexual men are currently thought to take more recreational partners than do heterosexual men, homosexual women, or heterosexual women. While a degree of sexual adventurousness may or may not be problematic for the couple, sexual relationships outside of the couple are likely to strain the relationship.

A controlled study of erectile and ejaculatory problems in gay and heterosexual men showed erectile dysfunction (ED) increasing with age and performance anxiety in both gay and heterosexual men. Overall, gay men scored higher on performance anxiety than heterosexual men in this sample. Rapid ejaculation was more prominent in heterosexual men than in gay men.[75]

Issues regarding the risk of AIDS are another source of strain on the couple, especially when one partner has HIV and the other does not, or when one partner takes more risks of acquiring HIV outside of the relationship.[76]

The most frequent form of male homosexual activity is fellatio and masturbation; anal intercourse occurs much less often. The frequency of high-risk sexual practices among homosexual males, such as unprotected anal intercourse and having multiple partners, has been changing in response to widespread concern about HIV. At first, fear seemed to motivate conservative sexual practices. More recently, however, practices have become less conservative as fearful avoidance gives way to informed risk-taking, apathy, or reckless despair.[77] While every couple must eventually face the prospect of functional decline and terminal illness, the HIV/AIDS epidemic has caused many gay couples to face these issues prematurely.

Lesbian couples typically express female characteristics, including less emphasis on genital contact, more rapidly decreasing frequency of sexual contact, more emphasis on emotional intimacy and nurturance, more exclusivity in relationships, and a greater inclination to long-term stability in relationships.[78] Many homosexual women have previous heterosexual relationships, marriages, and children. Some women return to heterosexual relationships following dissolution of a lesbian relationship.

The predominant forms of sexual activity between lesbians are oral-genital and manual genital stimulation to orgasm. Self-stimulation is frequently the preferred method. Dildo use, anal stimulation, and other practices are infrequently used. Infrequent orgasm, or no orgasm at all, is experienced by a minority of lesbians. Commitment and compatibility are at least as important as sexual activity and orgasm. The frequency of sexual activity in lesbian couples appears to decline to a greater extent than in couples with at least one male.

In the past, homosexual couples often lived together but downplayed their relationship in public as a means of avoiding discrimination. Many couples now live openly and assert the legitimacy of their relationship though symbolic marriage, various forms of legal union, and parenthood. Homosexual marriage has been recognized by a number of religious and political institutions. Further, a recent court case in New Jersey established the right of homosexual partners to hyphenate their last names, which overruled state policy to the contrary. The judge's determination included specific recognition of the legitimacy of same-sex, living-together-as-married status.

As same-sex couples become more open about their relationships, parenthood has seemed increasingly desirable and possible.[79,80,81] Homosexual couples often have children from previous marriages. In addition, lesbian couples are conceiving and bearing children through various high-tech methods, as are infertile heterosexual couples. Adoption is another road to parenthood for gay and lesbian couples. Adoption rights are subject to legal and bureaucratic rules, regulations, and administration. For these reasons, adoption rights are the focus of intense struggle for control of the moral agenda in the United States. For homosexual people, adoption is both a means of satisfying parental desires and a means of affirming social status.

Landmark cases are establishing the right to adopt. For example, as a result of an uncontested court case, the province of Nova Scotia, Canada, is revising its laws to permit adoption by same-sex parents. As the ruling was against a requirement of marriage for adoptive parents, the new provincial law enables unmarried couples of any sex match to adopt.

Gays and Lesbians in General Medical Settings

HIV/AIDS is an area of major concern when considering the health of a homosexual person. HIV/AIDS began in the United States as an illness of homosexual men, but has now spread to a much wider population and is an issue for all patients. HIV/AIDS continues to take a toll on the gay community and merits careful attention. The attention given to HIV/AIDS sometimes overshadows discussion of broader health care issues. The overall health care needs of homosexual individuals are similar to those of heterosexuals, yet homosexual individuals often find difficulty in accessing appropriate general medical care.[82,83] Mental health care needs must also be assessed and treated, as noted below.

Physicians and other medical personnel, aside from those who have special expertise in gay and lesbian health, may find difficulty in recognizing the needs of gay and lesbian patients and providing appropriate care. Two common barriers hinder health care delivery for homosexual individuals: (1) the lack of cultural competence among caregivers and (2) the ingrained, dysfunctional emotional responses of patients and caregivers. Neither of these obstacles is insurmountable. All physicians and health care programs should be able to deliver high-quality care to gays and lesbians if attention is paid to understanding homosexual culture and to management of dysfunctional emotions resulting in prejudice.

Cultural competence

Clinical encounters between straight doctors and gay or lesbian patients are likely to go awry when the doctor and patient seem to come from different worlds. The doctor does not know what questions to ask, and the patient feels that

trying to explain himself or herself is almost useless because the doctor seems hopelessly out of touch with the patient's situation. When this scenario occurs, the physician must pay more attention to his or her cultural competence with homosexual patients. The notion of cultural competence is often invoked in discussing care for refugee or ethnic populations, but it is needed as well with homosexual patients of both genders.[84]

To say that a physician is culturally competent is to say that the physician is knowledgeable about factors such as the historical identity, viewpoints, customs, lifestyle, language, literature, religion, socioeconomic status, or ethnicity of a particular group. Furthermore, cultural competency includes the ability to communicate effectively in ways that can be understood within the patient's cultural frame of reference. The culturally competent physician is able to understand patients on their own terms and to appreciate the various forces that shape their lives. Cultural competence does not mean physicians must abandon their own world views, but it does require physicians to refrain from needlessly imposing the perspective of their own subculture. A sizable volume of literature discusses the concept of cultural competence, its measurement, and how to develop cultural competence in health care programs.[85]

For a physician to provide health care appropriate to the patient's gender orientation and sociocultural setting, the physician must be able to take both a social and a sexual history. The history should address close relationships, sexual orientation, sexual practices, and sexual dysfunction in a sensitive yet thorough manner.[86] This data should be obtained from all adolescent and adult patients, regardless of gender orientation. Medical schools vary in the amount of training they provide regarding sexuality and interviewing skills. Physicians may benefit from a review of this area. Excellent study materials are available in both written and online formats.[87,88,89,90,91,92,93,94]

Emotional barriers to health care delivery

Emotional barriers to effective communication and health care exist in both patients and health care providers. In every clinical encounter, physicians must help patients feel enough at ease to discuss highly personal issues. In their daily work, physicians are continually called upon to manage their own emotional reactions to a wide variety of distressing situations. Managing the emotional aspects of caring for homosexual individuals is simply an expansion of the skills physicians bring to every clinical encounter.

Gay and lesbian patients may have attitudes that interfere with an effective therapeutic alliance. They may have negative and conflicting attitudes toward their own homosexuality.[95] They may be fearful of possible discrimination and very sensitive to even hints of homophobia in others. Physicians may counter these fears by conveying an accepting and supportive attitude within the framework of a compassionate professional relationship. Physicians should strive to use nonjudgmental verbal and body language, speak in a manner that is understandable to the patient, and demonstrate respect for the patient's values, goals, and aspirations. An interest in treating gay and lesbian patients can be conveyed by placing a book on this subject on the physician’s bookshelf in the consultation room.

Practitioners may also bring maladaptive attitudes and emotions to the clinical encounter. Many doctors find frank discussion of homosexuality to be anxiety provoking, and they have at least some conflicted feelings about clinical encounters with homosexual patients. If these attitudes go unrecognized, physicians may manage these emotions by avoiding homosexual patients or avoiding exploration and treatment of issues that involve sexuality and domestic relationships. Therefore, the first step is for the physician to recognize anxiety and avoidance when it occurs and to choose to overcome this emotion and behavior. With continued self-examination and repeated clinical contact with homosexual patients, the anxiety lessens to the point that the physician is able to form comfortable professional relationships with patients of all gender orientations.

HIV and AIDS

Homosexual patients are vulnerable to the same sexually transmitted diseases (STDs) as heterosexual patients. HIV/AIDS is of the greatest concern because of the serious prognosis. The risk factors for STDs include numerous sexual partners, partners with STDs, lack of safe sex practices, intravenous drug use, partners with intravenous drug use, and shared intravenous needles. Exploration of these issues is an essential element in primary care for gay patients as well as for all other patients.[96] A 2007 study of HIV-positive MSM residing in the UK showed that a subgroup affected with hepatitis C (HCV) in epidemic numbers had most probably acquired their infection through permucosal

transmission. High-risk behaviors more common in the infected group included group sex, more sexual partners, and sharing drugs via a nasal or anal route.[97] Furthermore, a study of men who have sex with men in Jiangsu Province, China concluded that STDs facilitate the transmission of HIV and the common factor in MSM with STD' was unprotected anal intercourse.[98]

When to refer for mental health services

General medical practitioners should be alert to the possibility of mental health concerns among gay and lesbian patients. Patients with significant depression, anxiety, adjustment disorders, suicidality, or other mental health issues should be referred for psychiatric or mental health evaluation and treatment. In particular, gay youths, especially males, should be screened for depression and asked directly about suicidality. Hospitalization should be considered in individuals who are acutely suicidal, dangerous to others, or incapable of meeting basic needs and in those who have medical issues that preclude beginning psychiatric care on an outpatient basis.

Conclusion

Homosexuality is the phenomenon of a person (male or female) preferring a partner of the same sex for sexual activity and intimate bonding. Homosexuality is not intrinsically pathological. While the terms homosexual and heterosexual are convenient labels, human sexuality is much more complex and represents continuums of behavior along several dimensions. Clear demarcations between homosexuality and heterosexuality do not exist.

Homosexuality has been present in human societies throughout history. The etiology is unclear but appears to involve a complex interplay of biological, psychological, and social factors. Contemporary Western society continues to discriminate against homosexual individuals, although in many social institutions most people are showing more acceptance of homosexuality, especially in the United States.

Psychiatric care for homosexual individuals is usually a matter of treating the same disorders that occur in heterosexual individuals from a culturally sensitive perspective. Screening for psychiatric disorders and providing appropriate care or referral are essential aspects of primary care. Screening for suicidality among young gay males is a priority. Homosexual individuals and couples are likely to have psychotherapeutic issues related to the unique aspects of living with a same-sex domestic partner and to the social and individual discrimination they often experience.

All physicians who deal with the general public must develop and maintain cultural competence in dealing with gay and lesbian individuals. Psychiatrists and general physicians should examine their own emotional responses to homosexuality to assure that they are able to provide care in a compassionate, professional manner free from the prejudice that gay and lesbian individuals often encounter.

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