Assessment and sexual concerns of gay men and lesbian women in a sexual medicine setting

Dr John Dean FRCGP, FECSM

Clinical Director, Gender & Sexual Medicine, Devon Partnership NHS Trust, Exeter, UK

Sexual Physician, St Peter's Andrology Centre, London, UK

The Laurels Gender & Sexual Medicine

Disclosures

- Within the past three years, Dr Dean has acted as a consultant to, or lecturer for the following companies on subjects unrelated to this clinical area:
  - Emotional Brain, Pfizer, Plethora, Repros Therapeutics

Sexual orientation

- Sexual orientation "refers to the sex of those to whom one is sexually and romantically attracted" [1]
- Gay, lesbian, bisexual and heterosexual are widely used descriptive categories, but research suggests that sexual orientation does not always conform to such definable categories and instead occurs on a continuum[2]
- Some research indicates that sexual orientation is fluid for some people; this may be especially true for women[3]

[1] American Psychiatric Association
[2] Kinsey, Pomeroy, Martin, & Gebhard, 1953; Klein, 1993; Klein, Sepekoff, & Wolff, 1985; Shiveley & DeCecco, 1977
[3] Diamond, 2007; Golden, 1987; Peplau & Garnets, 2000

Sexual orientation is not..

- Sexual behaviour (with whom I have sex)
- Erotic attraction (with whom I want to have sex)
- Sexual fantasies (about whom I fantasise)
- Affective preference (with whom I fall in love)
- Self-definition (with which community group I identify)

Sexual orientation and behaviours may be congruent or incongruent

Bisexuality may include…

- People who see themselves as attracted to 'both men and women'
- People who are mostly attracted to one gender but recognize that this is not exclusive
- People who experience their sexual identities as fluid and changeable over time
- People who see their attraction as 'regardless of gender' (other aspects of people are more important in determining who they are attracted to)
- People who dispute the idea that there are only two genders and that people are attracted to one, the other, or both

Bowes 2007

Fluidity

- Sexual orientation is inherently flexible, evolving continuously over the lifespan
- There are differences in change in orientation over time between gay men and lesbian women and between heterosexual men and heterosexual women, but not between bisexual men and bisexual women
- Lesbians report greater change than gay men for sexual fantasy, romantic attraction, and sexual behavior
- Heterosexual women report greater change than heterosexual men for sexual fantasy and romantic attraction

Internalized homophobia

- Despite progressive changes in socio-cultural attitudes, many people still consider homosexuality to be an undesirable state
- Internalized homophobia/homonegativity (IH) refers to the personal acceptance and endorsement of sexual stigma, as part of the individual's value system and self-concept
- It is the counterpart to sexual prejudice among heterosexuals

Herek, Gillis, & Cogan, 2009

Minority stress

- The presence of IH, and experiences of discrimination and violence, faced by homosexual and bisexual people, constitute what is called minority stress [1]
- Minority stress may impact upon access to care
- Minority stress may impact on psychological and emotional development, and personal relationships, making people more vulnerable to a variety of psychopathological conditions
- Some research suggests a significant relationship between IH, minority stress and harmful behavioural and mental health outcomes, such as HIV risk-taking among gay and bisexual men [2]

[1] Meyer & Northridge, 2006
[2] Hatzenbuehler et al., 2008

Barebacking

- "Bareback" is sexual penetration without the use of a condom
- In gay and bisexual populations, this is typically perceived as intentional unprotected anal intercourse among men who have sex with men where HIV transmission is a possibility
  - Involves intentionality and STI/HIV risk acceptance
  - Differs from "bug-chasing", where the claimed objective is to become infected with HIV *

* Moskowitz & Roloff, 2007

Motivations for barebacking

- Men who bareback report that, in doing so, they seek greater intimacy, connectedness, and physical pleasure in their sexual interactions and are thus willing to tolerate greater risk of HIV infection [1]

- Research suggests that advances in HIV treatments have contributed to some MSM's decision to bareback by decreasing their concern about seroconversion [2]

- Physicians need to be aware of these motivators and explore strategies to ameliorate risk of infection

[1] Manserghet al., 2002, Carballo-Dieguez et al., 2011
[2] Elford, J., Bolding, G., Davis, M., Sherr, L., & Hart, G. (2007)

Asexuality

- Asexuality has not been viewed as a disorder or illness across cultures and in history
- Professional constructs of sexual well-being, particularly amongst sexual medicine clinicians, are almost always accepting of the heterosexual-homosexual contrast as normative but are less likely to accept the sexual-asexual contrast

"We need to have more discussion about how people can not have sex and still be happy"

"We need to know we're not broken"

(David Jay, founding member of AVEN)

Same or different problems?

- Based on existing clinical knowledge, it can be stated that the range of sexual dysfunctions encountered in gay men and lesbians is similar to that found in the general population of men and women, and that the skills needed to address them are similar

- There are areas of concern, for patients and clinicians that merit particular attention

Gender roles

- In same-sex couples, a sexual relationship may be influenced by the absence of stereotypic gender-specific roles
  - Power dynamics may differ from those typically found in heterosexual relationships
  - Quality of sexual/intimate relationship may assume a higher priority than in a heterosexual couple
  - Same-sex couples are not dealing with opposing sexual role expectations (*macho* man and *submissive* woman) and tend to have a more varied sexual repertoire than heterosexuals

It’s not all about penetration

- Clinicians should not assume that sexuality is primarily focused on penetration
- Same-sex couples’ approach to pleasure can be very different from those of a heterosexual sexuality

It’s not all about monogamy

- “Non-monogamy” is more prevalent in gay male couples, but also in some lesbian couples
- Both partners in the couple might not accept this relationship style and some requests for help with sexual problems may conceal a difficulty of this kind

Coming out

- The clinician should consider the development of self-identity as gay, lesbian or bisexual and the process of coming out, to highlight any problems related to internalized homophobia

- Some sexual problems arise from living in a culture still hostile toward homosexuality

The clinician's baggage

- Work with same sex couples requires the clinician to suspend any preconceived notion about sexual orientation and any personal prejudices about sexual behaviours
- Clinicians have an ethical obligation to practice without discrimination
  - However, they must also be honest with themselves and their patients
  - If they find it impossible for them to work effectively with gay, lesbian and bisexual people, they should respectfully explain this and offer to help them find another therapist who can meet their needs

Assessment of orientation

- The aim of assessment is to collect all the information that will provide an accurate representation of any sexual problem
- It is important not to assume that the patient's sexual orientation is heterosexual
- Asking patients to "tell me about your relationship" and whether there are "any difficulties in the more intimate parts of that relationship" allow them to disclose their orientation and preferences for sexual behaviors

More baggage…

- The terms "active" and "passive" in gay relationships are best avoided, as they may be perceived to confer value judgments of specific behaviours or roles
- In order to understand a sexual problem, and how it affects each person, just ask each partner which behaviours they practice
- Do not assume that one partner is always "receptive" and the other "insertive" – listen and learn!

Assessment of the problem

Aside from the issues already described, which are largely related to preconceptions and acceptance of stereotypes, the assessment, clinical history and examination is unlikely to differ from the standard bio-psycho-socio-relational model

Assessment of the problem

When working with gay, lesbian and bisexual people, the clinician should explore the personal story of each partner, with particular attention to:

- Whether or not they relate sexuality with pleasure
- Their level of sexual knowledge
- Importance of masturbation
- Personal beliefs, values and prejudices
- Possible effects of IH, minority stress, and family and social group rejection

"In itself, homosexuality is as limiting as heterosexuality: the ideal should be to be capable of loving a woman or a man; either, a human being, without feeling fear, restraint, or obligation"

Simone de Beauvoir

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11-15 Dix's Field, Exeter, UK
EX1 1QA

Dr John Dean

john.dean1@nhs.net