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Pathologising alternate sexuality: shifting psychiatric practices and a need for ethical norms and reforms

Section 377 of the Indian Penal Code, criminalising consensual sexual activity between adults of the same sex, was framed during the British Raj and continued to govern Indian sexual relations until very recently. This law seems to reflect societal attitudes towards alternate sexualities. Such attitudes can affect the self-esteem and quality of life of people in the lesbian, gay, bisexual, transgender (LGBT) community who may then seek help from mental health professionals. Unfortunately, psychiatry has a history of pathologising homosexuality.

Recently, I was consulted by Mr A, a 26-year-old man, who identified himself as gay. A year earlier, when he had been questioning his own sexual orientation, he contacted a reputed psychiatric institute where the psychiatrist told him that his attraction towards men could be controlled, and that he could feel sexually attracted to women, by just completing a course of medicines. The patient quoted the psychiatrist as saying: "I guarantee that you can marry a woman after this treatment." Mr A agreed to take the medications and also started attending weekly therapy sessions at the same institute, but with a different psychiatrist.

Mr A said that for almost six months, his therapy sessions discussed every aspect of his life except sexuality. After six months when he insisted that they discuss his sexuality, the psychiatrist suggested that the medications would have started to work and he should "try out" the effect by "going and having sex with a girl." When the patient said that he did not know any girl who would agree to this, the psychiatrist suggested that he can go and "try out" with a commercial sex worker. Mr A did as advised but did not succeed. At the next consultation, the psychiatrist encouraged a "retrial…since one cannot infer anything from a single encounter." Mr A "tried" three more times, unsuccessfully. At this point, he realised three things: that he did not get sexually aroused by women, and that his sexual arousal for men had gone down. However, his sexual attraction for men remained unaffected, which was contrary to what the first psychiatrist had "guaranteed" a year earlier. When he went back to the first psychiatrist, he was asked: "Is marriage all about sex?" and advised a combined consultation along with the second psychiatrist. The patient did not go back to see either of them.

I read the prescription and saw that Mr A had been prescribed amisulpiride, escitalopram, amoxapine, lamotrigine and zolpidem for a full year. Amisulpiride, an atypical antipsychotic is used in the treatment of psychotic disorders. Escitalopram and amoxapine are antidepressants. Lamotrigine is a mood stabiliser used in bipolar depression. The patient denied having any history that could suggest depression, psychosis, or bipolar disorder at any time in his life. He stated repeatedly that the only reason for his consultation with the psychiatrists was the dilemma about his sexual orientation.

This case draws our attention to what some psychiatrists still practise today, thus making it difficult to draw a line on what they can treat and what they cannot or rather should not treat! Anecdotal reports suggest that many psychiatrists now use these classes of drugs under the pretext of helping the patient's depression or stress, possibly with the intention of reducing their overall sexual desire. This is a paradigm shift from the earlier behaviour modification techniques that were claimed to 'cure' homosexuality (1, 2).

A common side-effect of all these medications (except lamotrigine) is sexual dysfunction that may include decreased libido, erectile dysfunction and ejaculatory disturbances in men (3-6). Although these medications reduced Mr A's sexual arousal for men, they could do nothing as far as his innate attraction to the same sex was concerned, highlighting the fact that an individual's sexual arousal and sexual attraction towards another individual are governed neuro-biologically through different circuitry.

This case raises the issue of giving false assurances "guaranteeing a cure" when there is no evidence to support such a cure (7). It also highlights how a psychiatrist can breach therapeutic boundaries and suggest that the patient visit a CSW in order to see if the treatment is working. This case could just be the tip of the iceberg and there could be many more such LGBT patients who are misguided about a possibility of curing themselves of their natural sexual preferences?

Such incidents call for urgent reforms in the mental healthcare system, as well as in the wider healthcare system, to make them more LGBT-friendly. Redefining the role of healthcare professionals in these cases is urgently needed (8). An initiative on this front can be taken by national bodies and societies, individual institutes and healthcare providers. This would not only increase clients' trust in the healthcare system but also reduce the burden of their mental health problems.

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Critical perspectives on the NIMH initiative "Grand Challenges to Global Mental Health"

In July 2011 Nature carried a Comment titled "Grand Challenges to Global Mental Health"(1) announcing research priorities to benefit people with mental illness around the world. The essay called for urgent action and investment. However, many professionals, academics, and service user advocate organisations were concerned about the assumptions embedded in the approaches advocated and the potential for the project to do more harm than good as a result. Nature refused to print a letter (sent on 20th August 2011) protesting against the issue, citing 'lack of space' as the reason.

This letter is an effort to critique the initiative through wide participation and consensus.

Background

The largest international Delphi panel ever was assembled in a project starting March 2010 to formulate the 'Grand' Challenges to Global Mental Health project. The panel consisted of a scientific advisory board from the US National Institute of Mental Health who "nominated 594 researchers, advocates, programme implementers, and clinicians…researchers in genetics and genomics, neuroscience, basic behavioural science and neurodevelopment made up just over one-third of the panel. Mental health services researchers constituted another quarter, and a further third were clinical researchers and epidemiologists" (p 28).

The panel listed 25 grand challenges including biological, social and genetic factors that needed to be identified and tackled.

While environmental influences and community care were mentioned, the main framework for the project utilised a narrow 'medical' model for understanding mental distress that emphasised treating mental, neurological and substance-use (MNS) disorders through improved understanding of the brain, its cellular and molecular mechanisms. Fourteen MNS disorders were listed including unipolar depressive disorders, alcohol-use, schizophrenia, bipolar affective-disorders, epilepsy, panic disorder, migraine, insomnia, PTSD, and Parkinson's disease. The fact that disorders likely to be linked to adverse experiences (such as depression) were put alongside known organic pathologies (such as epilepsy) illustrated the lack of inclusion of lived social and political realities in the models for causation and manifestation of mental distress. In addition, while the authors proposed 'understanding root causes, risk and protective factors' including poverty, violence, war, migration and disaster, the essay largely advocated biomedical, clinical or 'social services' oriented measures to alleviate the distress, with no protest, voice or opinion against the root causes listed. They argued that MNS disorders constituted 14% of the global burden of disease surpassing cancer and cardiovascular diseases with a global loss of disability adjusted life years at 148.8 million. This programme is now growing in strength as it is being rolled out internationally (2).

Problems with the Grand Challenges project

The following are some of the main problems with adhering to the 'Grand Challenges' proposal:

a) We agree about the need to improve mental health in non-western countries, but are concerned about the approach of the 'Delphi panel' as developing appropriate frameworks for mental health requires active collaboration with local communities and with those with personal experience of mental health problems. The Delphi panel was not representative of these stakeholders. The data on which the Delphi panel bases its recommendations is also questionable and could grossly exaggerate the global burden of mental disorders.

b) The focus on 'molecular and cellular mechanisms' in the brain for the complex problems of living ignores the experiences of ordinary people and the different settings in which mental health problems manifest.

c) The recommendations overlook indigenous healing, social support networks, rights-based organizations and family support.

d) The assumption of a global norm for mental health and the idea that deviations can be subsumed within a simplistic biomedical framework is restrictive and disconnected from the real lived experiences of potential service users.

e) Mental health services should not be dependent on funds driven by pharmaceutical, insurance and other industries with potential conflicts of interest.

f) The picture of a black girl chained to a tree on the front page of their paper in Nature suggests that rights violations are a more prevalent issue in non-western countries. Mental health service delivery has involved rights violations across the globe (e.g. use of seclusion, restraint, high dose medication).

Instead we propose that protections, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), should be at the centre of developing mental health programmes. These programmes should also be developed in a way that reflects the experience of local communities.