Vulnerability of Thai Gays to Depression

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ABSTRACT

This study probed into the vulnerability of Thai male homosexuals to depression. A total of 50 participants were selected from two shopping malls in Bangkok, Thailand to answer a one-page survey checklist adopted from Polders (2009). Of the total respondents, 20 were 21 to 25 years old. Twenty-one classified themselves as gays, 18 as kathoeys or transsexuals and 11 as transvestites or transgenders. Results showed that most of the respondents were more open about their sexuality to their friends than to their own families, and that majority of them still felt unaccepted in their own community despite the public's impression of high gay tolerance in Thailand. As per inclination to depression, most of them admitted to have little pleasure and interest in doing things and were afraid of being physically abused and assaulted, yielding an average mean of 2.26 and 2.04, respectively (using a 4-point Likert Scale) as compared to Suicidal Ideation which yielded 0.26. There was no respondent who was clinically diagnosed with Major Depressive Disorder.

Key Words: Thai, depression, kathoey, homosexual, transsexual, transvestite, gender role, gender identity, gender presentation

Sex and gender are often used interchangeably; however, they are not the same. According to Cabaj et al. (as cited in Polders, 2006), sex is the biological distinction between males and females while gender refers to the maleness/masculinity or femaleness/femininity of an individual (as cited in Polders, 2006). What is considered masculine or feminine is not absolute, but rather socially determined and dependent on the culture of the individual (Polders, 2006).

Gender identity, like sexual orientation, is a complex construct (Polders, 2006). It is the inward and individual experience of being male or female or the ambivalence about one's maleness or femaleness (Martel et al., 2007). Gender role (or gender presentation), on the other hand, is one's public expression of his gender identity (Martel et al., 2007).

Transgender was originally used to refer to an individual who changed his social role to live fully in the gender role different from that assigned to him at birth without changing his body through surgery and medication (Martel et al, 2007). At present, this term refers to an

individual who experiences internal conflict with his physical sex, and/or his assigned gender role. Thus, it may now apply to any person who struggles internally over gender identity or whose physical characteristics and gender expression differ from his gender assigned at birth (Martel et al., 2007). Transsexual refers to an individual who takes medications and undergoes surgeries to bring his body in harmony with his inner sense of gender identity (Martel et al., 2007). As per US Department of Health and Human Services in 2001, a transsexual is an individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. They usually desire to change their bodies to fit their gender identities and do this through hormone treatment and gender reassignment surgery (Polders, 2006).

Homosexuality is a term that combines the Greek word, meaning "same" with the Latin word, "sex". The term was first used by Karl Maria Kertbeny in an 1869 pamphlet in which he argued for the repeal of Prusia's anti-homosexual laws. Later on, homosexual men (and women) considered the term "gay" to be used as a positive alternative to the clinical-sounding *homosexual*. This slang term was adopted by homosexuals as early as 1920 in the early gay civil rights movement and incorporated into slogans like "Gay is good!" (Marcus, 2005).

Homosexuality was initially introduced as a disease in 1952 when the American Psychiatric Association included it under the grouping of sociopath personality disturbances in the first edition of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM I). This move brought drastic changes to the gays' lives as they were routinely arrested and harassed by the police, fired from their jobs, expelled from universities, and denied housing (Marcus, 2005).

In 1980, the publication of DSM III introduced the diagnosis of Transsexualism for gender dysphoric individuals who demonstrated at least two years of continuous interest in removing their sexual anatomy and transforming their bodies and social roles. Others with gender dysphoria could be either diagnosed as Gender Identity Disorder of Adolescence or Adulthood Nontranssexual Type or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were ignored by the media who used the term transsexual for any person who wanted to change or had changed sex (genderpsychology.org, 2008).

In the publication of DSM III – R seven years later, the diagnosis of ego-dystonic homosexuality was dropped although a related disorder ego-dystonic sexual orientation still remained in the International Statistical Classification of Diseases and Related Health Problems – Tenth Edition (ICD10). Nevertheless, practitioners have

taken the position that homosexuality and bisexuality are not mental disorders (Martel et al., 2007).

In 1994, the DSM IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with strong and persistent cross-gender identification and a persistent discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood, Adolescence, or Adulthood. For persons who did not meet the criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS) was to be used. This category included a variety of individuals--those who desire only castration or penectomy without a concurrent desire to develop breasts; those with a congenital intersex condition; those with transient stress-related cross-dressing; those with considerable ambivalence about giving up their gender roles. Patients with GID and GIDNOS were to be subclassified according to the sex of attraction: attracted to males; attracted to females; attracted to both; attracted to neither. This subclassification on the basis of orientation was intended to assist in determining over time whether individuals of one orientation or another fared better in particular approaches; it was not intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "transgendered" began to be used in various ways. Some employ it to refer to those with unusual gender identities in a value free manner-that is, without a connotation of psychopathology. Some professionals informally use the term to refer to any person with any type of gender problem (genderpsychology.org., 2008). The diagnosis of Gender Identity Disorder (GID) is in the edition of the DSM IV - TR. This is used to pathologize children and adults whose experience and identification of their gender is opposite to that assigned to them at birth. This diagnosis was considered controversial because it is the only diagnosis that can be given to allow transgender individuals wishing to have hormone therapy or surgery to reimburse from their insurance (Martel et al., 2007).

In the latest version of the *DSM V, GID* will no longer be used in diagnosing transgender and gender-variant individuals. The American Psychiatric Association approved changes that would remove the term from the DSM V, replacing Gender Identity Disorder with Gender Dysphoria, a more neutral diagnosis of emotional distress over one's gender (Cameron, 2012).

Depression

Depression comes in many forms and for so many reasons (Cousens & Mayell, 2001). It can result from biological (genetics,

biochemical make-up, alterations in hormonal regulation, and sleep abnormalities), psychological (familial problems, assaults, conflict and turbulence in the home, parental upbringing, sibling favoritisms, and unreasonable parental demands), and social factors (family interpersonal relationships, social environment --- ethnicity and social class, interactions between genders across age groups). As discussed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR), it manifests in different ways and classified either as Major Depressive Disorder (MDD), Dysthymic and Bipolar Disorders. Parallel to Polders' study (2006), this investigation also focused on the socio-cultural stressors that can result to an individual's increased susceptibility to Depression. Depression in this study refers the socio-cultural context in which an individual operates, thus eliminating an extensive exploration of its clinical definition, though "vulnerability" is inclined to the somatic symptoms of MDD such as abnormal sleeping patterns (insomnia or oversleeping), abnormal appetite (gain or loss), headaches, loss of energy, and suicidal ideation.

REVIEW OF RELATED LITERATURE

Unlike other research topics, only a few articles on homosexuality and depression are recorded in Asia. Works done by Gallego, Gordillo, and Catalan (2000), Maopaiboon, Chommad, and associates (2003), Poon and Ho (2002), and Magn Sinnott (2002) were the only available Asian researches and articles related to Thai gays and depression. This is because homosexuality per se is a taboo subject that has been prohibited from being discussed in Asian cultures. It is something that is almost never discussed in schools, and when talked about is generally very negative and frequently associated with AIDS (Poon & Ho, 2002). According to Chung and Katayama's 1998 study (as cited in Poon & Ho, 2002), the strong intensity of homophobia among Asian families also brought great impact on the scarcity of Asian gay researches as it emphasizes rules of nature such as a well defined traditional gender role and family structure. Homosexuality also works against traditional Asian economic structures because most of its countries developed out of agricultural societies that relied primarily on human labor thus making the number of male children a great factor in the continuance of family culture and heritage (Chu & Sue, 1984 as cited in Poon & Ho, 2002).

The fact is, the LGBT population increases every year. In Thailand alone, an approximate of 910,000 gays or 1.4% of its total 65,000,000 population was tallied in the year 2005 (NextStopBangkok.com, 2006). The figures have been growing each

year but not much is written that investigate their lifestyle, psychological well-being or mental health, nor even to assess their needs. Thai researches that flourished were commonly centralized on gays and HIV, and gays and their transgender relationships as a result of the devastating consequences of HIV in the kingdom during the mid 1980's. But what is unknown to most is the connection between homosexuality and mental health. Perlstein (2004) reported that gay men are significantly more likely than adult men in general to be diagnosed as clinically depressed or distressed. Based on Dr. Thomas Mills' analysis of interviews of 2,881 men who identified themselves as having sex with other men in 2004, prevention efforts could help reduce the rates of depression and distress among gay men. They were able to point out that issues on anti-gay violence or threats affect their vulnerability to depression, and not merely identifying oneself as gay.

The development of the current research was done out of sheer curiosity, and as an attempt to build expertise on the correlation of gender and mental health. Specifically, this study aims to determine the vulnerability of Thai male homosexuals to depression, and how their sexual preference affect variables such as: self esteem, social integration, their experiences and fear of verbal, physical, and sexual victimization, drug and alcohol abuse, and their disclosure of their sexual preference. This research also aims to educate its readers and the general public of its findings and to encourage other researchers to undergo more in-depth local and international studies for the development of appropriate preventive interventions to specifically respond to their needs. In this study, the identified respondents were not clinically diagnosed with Major Depressive Disorder or MDD and that it excludes lesbians, and bisexuals of the LGBT Group to further emphasize its aim to specialize on a more specific population: Thai gays, kathoeys, and transvestites. Most of the researches used in this paper centered on the LGBT Group as a result of scarcity of materials and resources on Thai gays per se. Issues on control in social and psychological factors among the differing gay groups which include specific age brackets and developmental stage were also taken into consideration. The choice of research location was intentional due to Bangkok's immense availability of the research respondents. The survey / research tool used was adapted from the dissertation paper of Louise Alida Polders (2006) conducted in Gauteng, South Africa.

Violence against LGBT Youth and Adults

Violence against LGBT youth and adults is still a reality (Martel et al., 2007). Straight kids have a whole range of responses to their gay and lesbian peers --- from easy acceptance to thoughts and acts

of physical violence. In fact, the vast majority of the gay teens report that because of their sexual orientation, they are verbally, sexually, or physically harassed (Marcus, 2005) by their own families and communities (D'Augelli, 1998 as cited in Martel et al., 2007). Aside from being thought of as liars, cheaters, deceivers and manipulators (Marcus, 2005) and being stigmatized as a minority group, they also get verbally harassed, receive threat of physical violence, are attacked, and raped (D'Augelli, 1998 as cited in Martel et al., 2007). In some cases when victimized at home, these individuals cope by running away more frequently than their heterosexual counterparts thus resulting to higher incidence of substance abuse, higher self-report ratings of symptoms of psychopathology, and more sexual partners than heterosexual homeless youth (Cochran, Stewart, Ginzler, and Cauce, 2002 as cited in Martel, 2007).

Furthermore in the year 2002, D'Augelli and associates attended to one component of their previously administered questionnaire: victimization of LGB students in high school. As a result, more than half of its total respondents admitted to have been verbally abused, nearly a quarter were threatened with violence, and more than 10% have been physically attacked. The earlier these students identified themselves with their sexual orientation, the more they were victimized. Males were found to be victimized more frequently than females and that fear was also found to be a component of the victimization, with 30% of the LGB students fearing verbal abuse and 21% fearing physical attack. The study further concluded that verbal attacks were related to Posttraumatic Stress Symptoms and accounted for 9% of the variance in mental health symptoms. Over one-third of the students had made a suicide attempt, and 42% of the males and 25% of the females reported suicidal ideation. Bontempo and D'Augelli (as cited in Murphy, 2005) further examined the population and concluded that LGB youths who reported high levels of at-school victimization reported higher levels of suicidality than their heterosexual peers who also reported high levels of at-school victimization. This therefore indicates that differences in suicidality among LGB youths are meditated by victimization at school.

Self Destruction and Suicide

It has only been within the last 25 years that the study of youth suicide has become prevalent, and just within the last six years that suicide among LGB youths has begun to be examined using population-based studies, as opposed to older convenience-sample studies and post-mortem analyses relying on survivor perceptions of teen's sexual orientations (Murphy, 2005). In as early as 1981, Huxdly and Brandon

reported that 53% of their seventy-two transsexual youth respondents admitted to have had suicide attempts (Martel et al., 2007). Remafedi, Farrow, and Deisher (as cited in Martel et al., 2007) also found out that approximately forty-one out of its one hundred thirty-seven multiracial LGBT respondents had some form of intentional self-destructive act, with 21% of those resulting to hospitalization or medical care. The study made by Herrell, et al. (as cited in Martel et al., 2007) reported that males who had sex with men have higher risks of suicide than their twin brothers. In the said study, women were excluded, and the sample was homogeneous, thus limiting the generalizability of its findings. The 2001 data lists suicide as the eleventh ranking cause of death in the United States, but actually the third ranking case of death for youths ages fifteen through twenty-four (McIntosh, 2003 as cited in Murphy, 2005).

Homophobia, Ambivalence and Sexual Orientation

The closet is simply a metaphor used to describe the place where many gay and lesbian people keep their sexual orientation hidden. At its most basic, "coming out of the closet" means being honest with the people around about one's sexual orientation. Most gay and lesbian people grow up hiding their thoughts, crushes and relationships. Typically, they enter adolescence or young adulthood with the closely held secret that they are gay or lesbians. Gays and lesbians stay in the closet for a number of reasons: necessity, fear, and because they simply prefer or are accustomed to discussing this part of their lives with only a select group of people (Marcus, 2005). The intensity of homophobia in Asian cultures is clearly strong. Coming out is often not an option for many gay Asian men. Coming out in Asian cultures is not only about themselves but about their family as well. Many fear that their admittance may dishonor their family and/or the community may ostracize their family (Chan, 1996 as cited in Poon & Ho, 2002). In the study made by Poon and Ho in 2002, some of the participants revealed that their sexual orientation is often viewed as a temporary phase or they are told not to display their "homosexual behaviors" in public. The authors also added that because prejudice is so strong, some of the participants no longer hoped that they would be accepted by their friends and family but rather not prejudiced. Homophobia therefore is seen to have a strong impact on the psychological well-being of the gay, lesbian, and bisexual youth thus forcing them to stay in the closet. Poon and Ho (2002) stressed that their fears can lead to a tremendous amount of psychological stress and may result to social isolation. For many Asian gay youths, family is the only support they have. To deal with these emotional stresses, they,

especially those who lack positive coping mechanisms, may use substances, or may exclude themselves from cultural activities that may further alienate them from the community. To add, Nel and Joubert's 1997 study (as cited in Polders, 2006) stated that homophobia can result in prejudiced behavior towards gay men and lesbian women. This may happen in the form of avoidance of gay men and lesbian women, telling negative jokes about them, harassment thru verbal and physical means, and violence such as gay-bashing rape, destruction of private property and murder. Homophobic victimization is also referred to as hate crimes. The terms verbal victimization and hate speech can be used interchangeably.

Savin-Williams' investigation in 1991 revealed that ambivalence and one's sexual orientation may play a greater role in suicidal behavior in adolescents than sexual orientation per se. She stated that young men who rated themselves "predominantly heterosexual, but significantly homosexual" were more likely to report a suicide attempt than other minority male groups. Those who identified themselves as gay or bisexual according to the Kinsey Scale were no more likely to attempt suicide than heterosexual participants. However, in 1998 Safren and Heimberg (as cited in Martel, 2007) concluded that environmental factors, and not sexual orientation, play a role in distress among the LGBT youths, as the group differed on depression, hopelessness, and suicidal ideation. But taking a closer look on D' Augelli, Hershberger, and Pilkington's research in 2001, it showed that many adolescents who are not yet open with their sexual orientation might be in denial and suppression of their sexual feelings, which is related to their suicidality (Murphy, 2005). This study stressed out the association between sexual orientation and suicidality that yielded 42% admittance from its 350 LGB US, Canadian, and New Zealander youths that they sometimes or often thought of suicide, 33% with at least one attempt, and many related suicidal ideation and suicide attempts to their sexual orientation.

Unfortunately, one of ways that depression among the LGBT population manifests itself is increased drug and alcohol use and abuse, and internalized homophobia might be a primary cause. Gay children often grow up in a society that says that they should not exist and certainly should not act on their feelings. These societal feelings can be internalized. The conflict between what they feel and what they believe they should feel can cause psychological stress, and in an attempt to not "feel" some LGBT people turn to self medication with drugs and alcohol. Additionally, many gay and lesbian people have their first sexual experiences under the influence of alcohol. This might be a way to overcome the internal fear, denial, and anxiety about gay sex.

Alcohol use and sexual behavior can be conditioned together so that the pattern continues, and the depression can intensify (Swan, 2007).

The Lesbian, Gay, Bisexual, and Transgender (LGBT) Adults

Being Different. More and more evidences indicate that most gay men - at least 50% and probably more - remember intense feelings of being "different" from other boys and being labeled "sissies" by others. Because of this, some were rejected by their fathers, being afraid that effeminacy would tarnish the latter's own masculinity. Mothers, on the other hand, may have been the person gays clung to, leading them to be less independent than other boys and less social. The end result of being a "sissy" is often one's feeling of inadequacy, shame, and despair of being accepted by others and this dilemma makes establishing trust and intimacy a complex understanding. Family attitudes are also related to the shame a gay individual carries into adult relationships. As a result, being gay can feel like a terrible way of letting everyone down. Men whose anger is inhibited by shame sometimes are abused in relationships. They may see this as a confirmation of their worst fears, that they are unlovable and relationships are sources of hurt (Driggs & Finn, 1991).

Denial, Secrecy, and Shame. Feelings of attraction toward the same sex may hover in the background of one's consciousness. For some men, the attempt to block out gay feelings may result in severe psychological symptoms such as depression, anxiety, or sexual dysfunction. If one's gay feelings are suppressed, one also numbs himself --- then loses his ability to feel by blunting anger, compassion, and empathy. By keeping quiet about one's sexuality, it is also the same as showing one's awareness that he cannot trust everyone to be supportive of his gay feelings. Moreover, it also affects one's self-esteem and therefore affecting his interpersonal relationships. A prolonged period of hiding gay feelings can leave an individual confused about issues of secrecy and privacy, especially when it comes to sexual matters. Gay men are particularly prone to shame because a vital part of themselves is so clearly condemned by culture. And although other groups are looked down upon by society, gay men are different in being able to hide that part of themselves that is frowned upon. When a secret is disapproved of, intense shame is almost always the result (Driggs & Finn, 1991).

Coming Out. The joy that comes from disclosing one's sexuality to someone else and being accepted is a sign of the growth toward acceptance. Self – acceptance is essentially an internal decision to love and cherish a part of oneself that may be scorned by others. It is when one says, "I have to be me, no matter what other people think". Although self-acceptance is partly a personal process, no one can develop feelings of being valued, accepted, and worthwhile in complete isolation (Driggs & Finn, 1991).

Dealing with the Family. Strains do not just exist in the past. They can actually result in lingering hard feelings between an individual and his family, thereby one of one source of support and closeness in adulthood. Also, the family patterns that develop around boys who are effeminate can affect their close relationships as adult men. Rivalrous relationships with brothers and sisters can also lead to competitive relationships with lovers and friends. Overprotective mothers can leave one thinking of not surviving life's demands without the protection of that one particular person. The reaction one gets from being gay have profound effects on one's self-esteem (Driggs & Finn, 1991).

Harassment. Harassment of adult gay and lesbian people ranges from name-calling and spray-painting antigay epithets on the houses to slashing tires on cars parked outside gay bars. All too often, antigay incidents go well beyond name-calling to death threats, beatings, and even murder. In 2003, six men and women were killed in the United States because of their sexual orientation. That was the same year when 1,430 hate crimes were reported based on sexual orientation. University of California psychologist Dr. Gregory M. Herek, the author of *Hate Crimes: Confronting Violence Against Lesbians and Gay Men*, states that for most people who are biased against gay people, homosexuals "stand as a proxy for all that is evil . . . such people see hating gay men and lesbians as a litmus test for being a moral person." Other psychologists also state that bias results from a combination of fear and self-righteousness in which gay people are perceived as contemptible threats to the moral universe. These antigay feelings are often supported by religious institutions that consider homosexuality to be sinful. Young people in particular are often motivated in their verbal or physical attacks on gay people by a desire to be a part of the crowd or to gain approval of their peers or family (Marcus, 2005).

According to Gallego, Gordillo, and Catalan in 2000, the most frequent diagnoses in homosexual men are Major Depression and Substance Abuse, especially Alcohol Use Disorder. Poor social support

and the use of avoidance or denial as a habitual way of coping were the identified factors that relate negatively to disease adaption, but positively to psychiatric morbidity. In line with this is that of Martel and associates in 2007, where it was concluded that LGBT adults suffer specific psychological problems at higher rates than their heterosexual counterparts, and that transgender individuals are vulnerable to psychological distress. Cochran and Mays (as cited in Martel et al., 2007) reported higher rates of depression and panic among men with same-sex partners and higher rates of alcohol and drug dependence among women with same-sex partners. In 2003 with Sullivan, they used data from individuals who identified themselves as LGB and found out that gay and bisexual men were likely than heterosexual men to be diagnosed with a mental disorder. Indeed it was confirmed that there was an elevated risk for mood, anxiety, and substance abuse among lesbian, gay, and bisexual adults. Specifically, gay and bisexual men were 3 times more likely to be diagnosed with Major Depressive Disorder and 4.7 times more likely to be diagnosed with panic disorder.

Discrimination and Mental Health. Depression and anxiety affects every country and society in the world, according to what is believed to be the world's most comprehensive study of these mental disorders, conducted by researchers from the University of Queensland, Australia. The researchers carried out two separate studies that focused on anxiety disorders and major depressive disorder. Researchers analyzed surveys of clinical anxiety and depression that had been conducted across ninety-one countries, involving more than 480,000 people. In Western societies, anxiety disorders were more commonly reported than in non-Western societies, including countries that are currently experiencing conflict. About 10 percent of people in North America, Western Europe, Australia and New Zealand were experiencing clinical anxiety compared to approximately eight percent in the Middle East and six percent in Asia. The opposite was true for depression, with those in Western countries least likely to feel depressed. Researchers found that depression was the lowest in North America and highest in certain areas of Asia and the Middle East (Pedersen, 2012).

It is probably quite obvious why members of the LGBT community are more susceptible to depression. Whether or not one is open about it, simply being gay creates an additional stress factor that straight people do not have. Hiding one's gay identity means a great deal of anxiety about being found out, while homophobia makes life less than being peaceful if open about it. Gays and lesbians who struggle with their identities have additional anxieties about not fitting

in with either mainstream society or the LGBT community (Swan, 2007).

In a study that examines possible root causes of mental disorders in LGB people, it was found out that discrimination and mental disorders were related (De Angelis, 2002). In another study cited in De Angelis (2002) that looked into discrimination and mental health, findings revealed that LGB respondents reported higher rates of perceived discrimination than heterosexuals in every category related to discrimination. While results do not prove that discrimination causes mental health problems, they take a step toward demonstrating that the social stigma felt by LGB people has important mental health consequences (DeAngelis, 2002).

Another research on mental health and homosexuality done by Chakraborty (as cited in Collingwood, 2011) in United Kingdom looked at rates of mental disorder among 7,403 adults living in the UK. Findings revealed that rates of depression, anxiety, obsessive compulsive disorder, phobia, self-harm, suicidal thoughts, and alcohol and drug dependence were significantly higher in homosexual respondents. Four percent had a depressive episode in the last week, compared to two percent of heterosexual people. The rate of alcohol dependence was ten percent versus five percent, and for self-harming it was nine percent versus five percent. The proportion of homosexual people who described themselves as being fairly or very happy was 30 percent, versus 40 percent for heterosexual people. This implies that non-heterosexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and self-harm than heterosexual people. In addition, although the level of discrimination was low, it was still significantly higher than against heterosexual people. This lends support to the idea that people who feel discriminated against experience social stressors, which in turn increases their risk of experiencing mental health problems. These higher levels of psychiatric problems in homosexual people call for greater efforts at preventing the issues arising. As a conclusion, the study stated that discrimination on the grounds of sexual orientation predicted certain neurotic disorder outcomes, even after adjustment for potentially confounding variables (Collingwood, 2011).

Whether or not discrimination is the cause, mental health problems have previously been found to be higher among homosexual people. In 2008, King and his team carried out a review of 28 papers on the same subject. All were published between 1966 and 2005, and included a total of 214,344 heterosexual and 11,971 homosexual people. Their analysis revealed twice the rate of suicide attempts among lesbian, gay and bisexual people. The risks of depression and anxiety disorders were at least one and a half times higher, as was alcohol and

other substance abuse. Most of the results were similar in both sexes, but women were particularly at risk of alcohol and drug dependence and men at a higher risk of suicide attempts. The researchers stated that there are a number of reasons why gay people may be more likely to report psychological difficulties, which include difficulties growing up in a world orientated to heterosexual norms and values and the negative influence of social stigma against homosexuality. In addition, the gay commercial world in which some men and women may participate to find partners and friends may make misuse of alcohol and cigarettes more likely. Finally, results add to evidence that sexual experiences in childhood in men classified as gay or bisexual may play a role in adult psychological adjustment," they conclude (Collingwood, 2011).

Causation of Depression and Adolescent and Adult Homosexuality

Previous studies have concluded that: (1) gay men, lesbians and bisexuals appear to have higher rates of some mental disorders compared with heterosexuals, although not to the level of a serious pathology. Discrimination may help fuel these higher rates; (2) Higher rates of recurrent major depression are present among gay men; and (3) Higher rates of anxiety, mood and substance use disorders, and suicidal thoughts among people ages 15 to 54 with same-sex partners (DeAngelis, 2002).

Gay men are born into a world where they are frequently told that their feelings are bad. The message sometimes comes from family, and people at school, in church, and in the community. Total strangers often feel free to make inappropriate remarks to gay men. Even other gay men, hoping to hide their own sexual orientation, will sometimes disparage a gay man. It comes as no surprise then that gay men frequently suffer from low self-esteem, accompanied by depression. When a man has low self-esteem, he will often overlook his physical well-being, leading to a spiral of more guilt and depression. In addition to all the negativity from the world around him, a gay man still has his career to contend with, personal relationships to balance and bills to pay. He has all the "regular" stresses of modern society, with the added pressure of dealing with his sexual identity (Sparks, 2013).

The causes of depression can be hard to pinpoint, but we do know that environmental factors can act as "triggers," sending a person into a downward spiral. As we discussed in the previous section, stress and anxiety are often associated with depression. Other factors that may act as instigators include the sudden death of a loved one, a difficult physical illness, hormonal changes, medications, or substance abuse. People with a personal or family history of depression may be more likely to become depressed (Swan, 2007).

Although the causes of depression are sometimes unclear, we do know that clinical depression is accompanied by a chemical imbalance in the brain. The brain uses chemicals, known as neurotransmitters, to relay messages. Neurotransmitters are fairly specialized, with each one controlling a different type of message. For example, a lack of serotonin – the "happy chemical" – is believed to be linked with the irritation, anxiety, and difficulty sleeping associated with depression. Shortages of norepinephrine, a neurotransmitter than controls alertness and arousal, may be related to tiredness and depressed mood. However, it is not known whether the chemical imbalance causes depression, or vice versa (Swan, 2007).

Addis and Martel (2004) simplifies depression as something that is usually seen as inside oneself. It may be something like a chemical imbalance, poor self esteem or negative thoughts or beliefs. People affected by it typically see themselves first, and they see themselves as very dim. They tend to see the bad rather than the good. It must be stressed though that Depression is a problem between an individual and his own life, and not a problem that is inside oneself. It can be overcome by recognizing behavioral habits that have developed over a lifetime and learning to change them.

DSM-IV-TR's report on the prevalence of MDD states that it is twice as common in adult females as in adolescent and adult males. In prepubertal children, boys and girls are equally affected. It was also mentioned that MDD is not related to ethnicity, education, income or marital status. Corollary to this, it was found out that doctors estimate that as many as eight million women and four million men in the United States are treated for major/clinical depression each year. Almost forty million Americans frequently fall into chronic negative moods characterized by loneliness, boredom, and restlessness, according to an extensive survey of tens of thousands of adults. As few as one in ten people who could benefit from mood-elevating drugs or supplements are currently taking them. In the United States alone, an estimated twelve million people suffer from depression without actually realizing it. Studies moreso suggest that as few as one in twenty people suffering from depression receive a prompt and accurate diagnosis and an effective treatment (Cousens & Mayell, 2001).

Homosexuality in Thailand: The Kathoeys versus the Gays

Rak-ruam-pheet or homosexuality is a mid-twentieth-century addition to Thai vocabulary that is into three: Gay, Kathoey, and Transvestite. In the Thai community, a gay person is a man (or woman) who is homosexual. Before, male homosexuality was equated to a kathoey (Jackson, as cited in Sinnott, 2002), an indeterminate gender or

a combination of masculine and feminine gender usually translated to English as the third sex (Sinnott, 2002). However, three decades ago, some homosexual Thai men formed a personal identity that distances itself from a *kathoey*. These men started to use the English term 'gay' as a positive self-referent in which they position themselves as extensions of a transnational gay identity (Sinnott, 2002). In contemporary usage, the word *kathoey* is commonly used to refer to a man who biologically appears to embody what are understood to be feminine characteristics (Sinnott, 2002). Lastly, a Transvestite refers to an individual who does not go surgical reassignment / realignment but conforms to the opposite sex gender roles to varying degrees, thus including those who choose to wear drag (Sinnott, 2002).

Buddhist origin myths used to describe three original human sex / gender – male, female, and the biological hermaphrodite (Allyn, 2005; Winter, 2007) or kathoey. The kathoey was not defined merely as a variant of male or female, but as an independently existing third sex, though perhaps with a secondary meaning of a male who acts like a woman (Allyn, 2005). It is an intermediate gender or a combination of masculine and feminine gender, or a man who appears to embody what are understood to be feminine characteristics (Sinnott, 2002). The term can carry negative connotations and kathoeys are not comfortable with it maybe because the word itself implies that one is a variant of male rather than female (Winter, 2007). Kathoeys are visible in Thai society but are not yet accepted by the mainstream (Cameron, 2006). In this Southeast Asian country, it seems that even the smallest village has at least one, and it is remarkable how many kathoey's family and neighbors do not shun him, though his family may be very distressed about it. He may be teased and flirted with, and he is surely the subject of much gossip, but he is still a part of the family, the clan, and the village. Not all kathoeys enjoy this kind of reluctant acceptance or even toleration (Allyn, 2005), with families varying in their levels of acceptance, responding either with sadness, rejection and denial, anger, or violence (Cameron, 2006). Many cross-dressing and gender dysphoric males do have stormy conflicts with their fathers in particular, and are subjected to verbal abuse by peers and strangers. In this new millennium, several issues are seriously dealt with the kathoey face – a disapproving father, the cruel remarks by strangers, and his frustrations in finding true love (Allyn, 2005). As a matter of fact, a study of eighty kathoeys and gays concluded that fathers were less accepting of their identities with only 38% reporting to have fathers who accepted them (Cameron, 2006).

The traditional Thai sexuality did not reflect clear distinctions between homosexuality and bisexuality as explicitly drawn by Western cultures (Taywaditep, et al., 2003). When the English term "gay" was

introduced to the Thais, it referred mainly to a cross-dressing or effeminate homosexual male (Nanda, 2000). For almost three decades until recently, it has been popularly used by the Thai public as another word for kathoey or ladyboys, she - males, and transgendered males (Allyn, 2005; Jackson, 1996), or a person or animal of which the sex is indeterminate (McFarland, 1982, as cited in Taywaditep, et al., 2003). Since the early 1970's, a confusion between the bisexuals and homosexuals from the kathoeys arose (Jackson, 1996). Nanda even supported this when she stated in her research last 2000 that until the 1970s, males and females, (biological) hermaphrodites, and cross-dressing men and women could all come under the umbrella term, kathoey. To address the rising conflict, Thai gay men in effect formed a personal identity that attempted to distance themselves from the transgendered kathoey (Sinnott, 2002) where there took place a transformation of verbs that describe homoerotic behaviors between men and kathoeys to a series of new nouns that label the gender status of bisexual and homosexual men. These nouns finally were used to describe and differentiate the bisexuals and homosexuals from the kathoeys (Jackson, 1996). However, throughout the 1990s, a masculine-identified homosexual male identity emerged (Allyn, 2000) that is as equally or even more concerned with his masculine identity than heterosexual men and modeled himself on the dominant masculine image except for his sexual orientation (Nanda, 2000). As the gay men were identified with gym-enlarged biceps and pectoral muscles and with accentuated bodies and facial hair (Nanda, 2000), the kathoeys became increasingly criticized by the Thai, and were classified into two: the ostentatious and the classy (Allyn, 2000), and started to face increasing social and sexual stigmatization, and even physical violence (Jackson, 1997 as cited in Nanda, 2000). The kathoey's cross-gender persona, with its assumed permanent sexual subordination in the receptor role, then made him a kind of "deficient male" or an independent sex / gender category (Nanda, 2000). Gay men stressed that gayness is masculine and gay relationships are more than sexual. With these social changes, young gays clearly benefitted as they experienced more sexual and romantic freedom, gaining more straight peers and boyfriends (Allyn, 2005). In summary and as a result of the shifts in meaning, the term kathoey today is most commonly understood as a male transgender category, which in different contexts can refer to transvestites, hermaphrodites, transsexuals, and effeminate homosexuals, or formally defined as males who do not conform to Thai gender norms (Nanda, 2000). They are now those men who have feminine social behaviors without much specific reference to their biological gender or sexual behavior (Taywaditep, et al., 2003). On the other hand, the term "gay" or "gay men", now with a stronger

disassociation from the kathoeys became well established among educated and middle class (Nanda, 2000) and became more distinct and began to be more widely used to refer to masculine identified men who are emotionally and sexually attracted to other males (Allyn, 2005).

The cultural and personal identities of the gays and the kathoeys are products of recent historical transformation. The medical, psychological, and sociological discourses that have been produced and appropriated by the state to regulate and define homosexual men and women are products of an urbanizing, industrializing twentieth century Thailand, and not just leftovers of some timeless past. The traditional understanding of what is now called "homosexuality" in Thailand relies on the primacy of gender rather than sexual behavior per se (Sinnott, 2002). Even before the 1960s, Thai homoerotic relations were structured: masculine and feminine persons were ascribed to same-sex partners. This was reinforced by related oppositions that established a power hierarchy between the junior and the senior, the inserter and insertee (Jackson, 1999). Another reinforcement pointed out was the notions of class and social status: the kathoeys being the low class, while the gays as the more prestigious ones.

At the beginning of the same decade, Thai physicians and psychologists attempted to control, suppress, and cure cross-dressing and homosexuality using Western biomedical sciences. Its effectivity was at the same time as the press exposed the existence of a diverse array of new identities and cultures, which in effect gave the project an impression that it was only incited into being by the presence of the new identities and that it just drew upon Western knowledge (Jackson, 2003). In the same article, Jackson pointed out that the history of religious and legal prohibitions of homosexuality and the medical and psychiatric projects to cure same-sex desires resulted to a constellation of powers which gave the homosexuals a concrete social existence. He further stated that as the Queer Theory supports, he believes that the history of sexuality and the proliferation of sexual identities in the West relies on the argument that new regimes of biological power incited new sexualized understandings of the self, thus becoming a basis for new forms of culture and new forms of social organization. As this western "scientific" biomedical discourse on sex and gender was introduced in Thailand, it emphasized the difference between homosexuals - who were viewed as "psychological inverts" and the kathoey – who were viewed as biological hermaphrodites (Nanda, 2000).

With very little homophobic physical violence or overt antagonism against homosexuals (Cameron, 2006), Thailand is not a homophobic society (Allyn, 2005). As a matter of fact, even Peter Jackson in 1999 clearly stated that the Thai culture has liberal, accepting attitudes towards transgederism and masculine-identified

male homosexuality. Thais do not culturally fear nor despise homosexual behavior and homosexual men. In fact, even those Thais who accept western homophobic ideas do not let these impact their social attitudes.

The Homosexual's Social and Sexual Lives and the Gay Community. Networks are the dynamic systems of social and sexual relationality that define the pathways of social and educational influence (Dowsett, Grierson, and McNally, 2003). McCamish et al. (as cited in Dowsett, Grierson, and McNally, 2003) noted the overlap between 'commercial' and 'non-commercial' networks and the intersections the two have with heterosexual networks by elaborating the difference between the networks in Bangkok and Pattaya: In Bangkok, there is considerable mobility between bars with lower social bonding, whereas high social networks in Pattaya remain in the same bars for long periods.

The average masculine-identified gay's sexual life is private and personal. His initial fears of turning into a kathoey, and facing indistinct consequences of losing face when his sexual life is discovered makes him take advantage of his personal freedom and becomes satisfied with his daily interactions with his family, friends, and co-workers, while his gay activities remain viewed by all as private like heterosexuals as well. Many Thai males who are sexually and emotionally oriented toward other men express anxiety and shame about the consequences of their homosexual behavior being publicly exposed. Yet, many gay magazines publish personal advertisements with photographs of men seeking other men, suggesting an astonishing lack of concern about "exposure" or perhaps ultimate bravery (Allyn, 2005).

As reported by Allyn in 2005, Thais have adapted some superficial aspects of the Western gay culture by travelling and thru the media that even the Westerners see the difference between that of theirs and the Thais. Despite exposure to the Western gay culture, the Thai gay community barely exists except in some cities. Some think that social and political organizations are not necessary because they are not oppressed, while some grapple with their identities and feel repressed because of some social forces (not specified) and a lack of a clear definition of what being gay really means. Creating a formal Thai gay organization yielded tensions caused by group gossip and competition for the attention and loyalty of its members and outsiders. Also, Thai social system is a strong barrier to groups that attempt to have an open membership because the middle and higher classes do not mix well with the lower class. Another brake on the development of a Thai gay community are a lack of homophobia or explicit social opposition in

Thai society and that new gay men perceive themselves as outsiders. Informally though, communities with loose boundaries and affiliations still exist through gay bars, saunas, and pub-restaurants. The middle and higher classes of gays seem to be contented to create circles of friends and meet at these venues instead, while the lower ones create networks at local pubs and discos (Allyn, 2005).

METHOD

Research Design

This is a qualitative research that aimed to generate generalizable leads and ideas about the vulnerability of Thai Male Homosexuals to Depression. A survey questionnaire was used to reinforce its results and evaluate its findings.

Participants

Fifty Thai homosexual men participated in the study. They were randomly selected in two Cheerdance Competitions in two different places: SeaCon Square and The Mall Bang Kapi.

Most of the respondents are between 20 to 25 years old, with 42% of them identifying themselves as gay men. No respondent was forced to participate in the completion of the study. Confidentiality was ensured as it was noted on the questionnaire itself and that no names or any distinguishing marks were put on any of the distributed materials.

Instrument

The instrument used in this research was adapted from a 2006 dissertation of Louise Alida Polders of the University of South Africa, in which she explored the factors affecting vulnerability to depression among gay men and lesbian women in metropolitan Gauteng, South Africa. The questionnaire was designed after having conducted exploratory interviews with key members of Gay Communities / Organizations in South Africa. Twelve pilot testing was conducted (including one respondent from each main sampling cluster) and proper validation was made to ensure that the questionnaire will yield results that can generalize its population.

It initially comprised of 14 pages which included instructions, assurances of anonymity and confidentiality, and research purpose. It was trimmed down to a simplified, single-paged questionnaire for the purpose of this study. Demographic questions were limited to age

(expressed in brackets), homosexuality classification (gay, kathoey, transvestite), and the degree of openness about one's orientation.

The original English format of the questionnaire was translated to Thai by an accredited translator from Thai Translation and Thai Interpreter, Inc.

Items on vulnerability to depression were scored on a 4-point Likert scale form "Never" (scored 0) to "Always" (scored 3). The original questionnaire used the Likert 1-4 (1=Never; 4=Always). It was changed to 0-3 to lessen the complications and confusion that the numbers may cause. It included somatic symptoms of depression such as headaches, insomnia, increased or decreased appetite, difficulty getting up in the morning, and suicidal ideation. Higher scores indicated an increased vulnerability to depression.

Procedures

The participants were politely approached and asked to complete the 1-page survey of the study. Average answering time was around 3 to 5 minutes, with minimal and simple questions asked. The respondents were not brought to a secluded area like a testing room when the survey was conducted. They answered the questionnaires in the places where they were, despite some noise and destructions during the course of the activity. Results show that all answered in full confidence and knowledge about the topic.

RESULTS/FINDINGS

The survey shows that 40% (20) of the respondents were adults in their early to mid 20s. Twenty eight percent (14) of them were aged 26-30 while 11 or 22% were aged 31 and up. Only four (4) individuals were at their teens and a single 14-year old (or could have been younger) participated in the research (refer to figure 1).

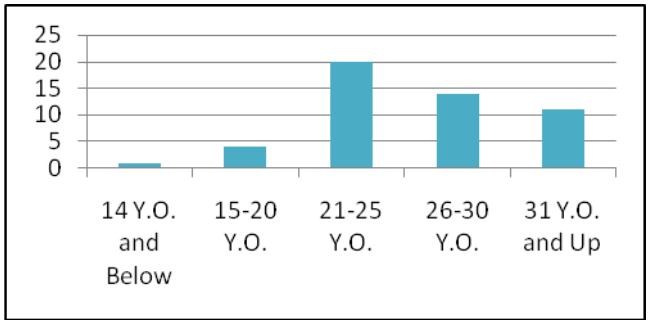

Figure 1 Demographic Profile According to Age

With regards to classification, most respondents were gays, comprising 42% of its total sample size (21 out of 50). The distribution between the three classifications were not far from each other since the Kathoeys made up 36% of its total respondents and the Transvestites made up 22% (Figure 2).

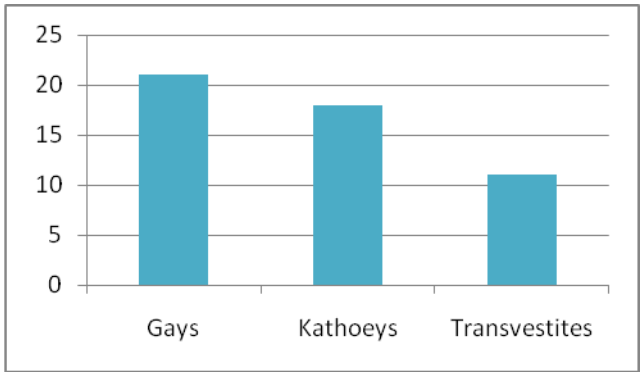

Figure 2 Homosexual Classification

Figure 3 shows the respondents' feelings about themselves in the community. It is clearly shown that majority of them (42%) feels that they are not part of the community or of the group. Far enough were those who feel well accepted, comprising 28% of the total 50. 18% or 9 out of 50 thought that they are socially popular, opposite to the 8% who thinks that they are just nobody's and the 4% very socially popular ones.

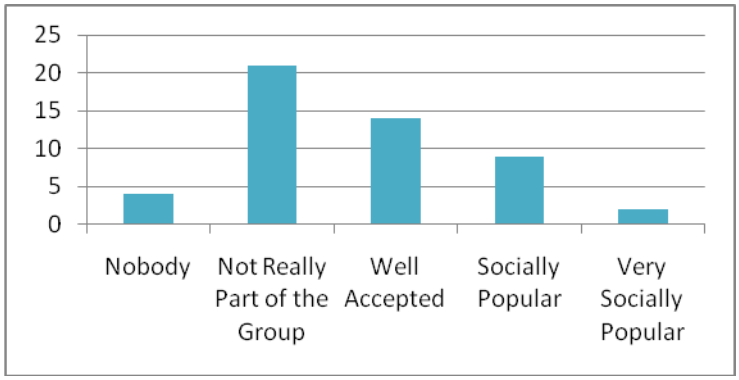

Figure 3 Self Concept When In The Community

Sixty percent of the total sample size admitted that they drink alcohol and even consider themselves as "Alcohol Users (Figure 4).

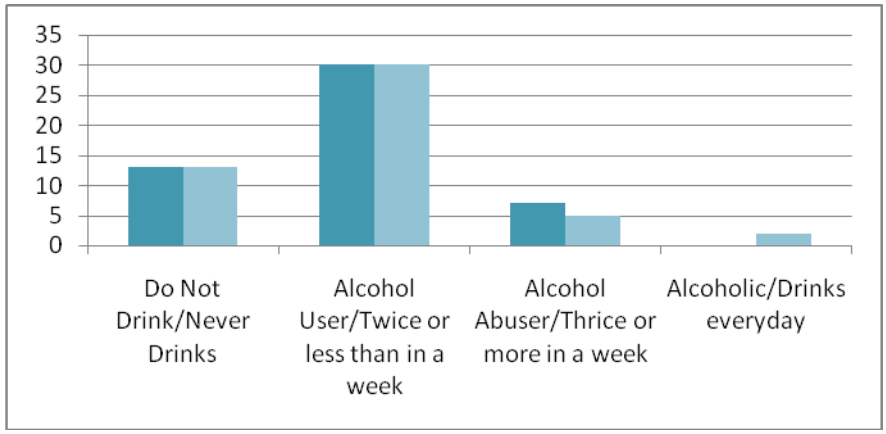

Figure 4 Attitude Towards Alcohol and Frequency of Alcohol Intake

Unlike the previous results on Attitude towards Alcohol and Frequency of Alcohol Intake, those that refer to Drugs were consistent. 92% or a total of 46 respondents do not take drugs with the same number to have never used recreational drugs. Both Users and Abusers gathered a percentage of 4 (2 respondents each), same as those who tried to use recreational drugs and those who take drugs thrice a week or more (refer to figure 5).

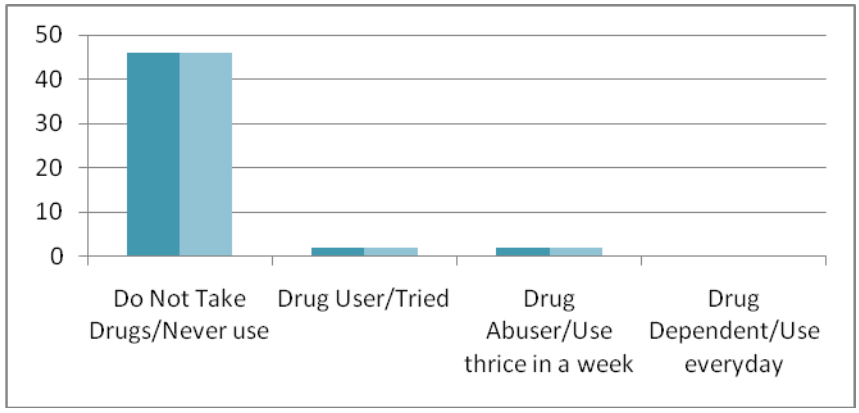

Figure 5 Attitude Towards Drugs and Frequency of Drugs Intake

Presented below are tables that show how the respondents answered the vulnerability to depression and the fears and fears of victimization parts. Listed are the exact statements which the respondents rated with 0 to 3 (Not At All to Nearly Everyday). Results are already ranked according to highest to the lowest scores to stress the immediacy and intensity of assistance regarding the matter.

Table 1 clearly shows that with an average of 2.26, most of the respondents feel little interest in doing activities. Next are overeating and oversleeping. It is also apparent that feeling down, depressed, or hopeless is related with feeling like a failure as both garnered an average score of 1.06. It is a good sign though that not a lot of the respondents answered one to three on the suicidal ideation part as it only gathered an average score of 0.26. With a total mean score of 0.98, the respondents showed low vulnerability to depression.

Table 1
Vulnerability to Depression

Ave. Score	Somatic Symptoms of Depression
2.26	I have little interest or pleasure in doing things.
1.32	I overeat.
1.12	I sleep too much.
1.08	I feel tired.
1.06	I feel down, depressed, or hopeless.
1.06	I am a failure.
1.02	I have a poor appetite.
0.96	I have trouble concentrating on things.
0.92	I feel like I have very little energy.
0.82	I have trouble falling or staying asleep.
0.54	People notice that I move and speak slowly.
0.36	I think of hurting myself.

0.26	I think of ending my life.

With a total mean score of 0.976, the respondents' emotional well being is considered intact. Most scored low on well-being especially on the item that states that feeling of uselessness (0.58), which is actually a good sign. Not too far from each other's scores are those on seeing oneself as not as happy as the others and that of rejection with a 0.62 and 0.66 average scores respectively. Having a possible highest score of 3, feeling to like to have 2 lives scored quite above the average with 1.98, while belongingness scoring far from the item previous and after it with a score of 1.04 (refer to table 2).

Table 2
Well Being

Ave. Score	**Scale Items**
1.98	I feel like having two lives.
1.04	I feel like I don't belong.
0.66	I feel rejected.
0.62	I am not as happy as others seem to be.
0.58	I feel useless.

The last component of the study is victimization: Fear of physical sexual and verbal attacks and actual experiences of physical, verbal and sexual attacks. Items on this part show apparent extremes on the scores from being afraid of being abused to the actuality of being abused (refer to figure 6).

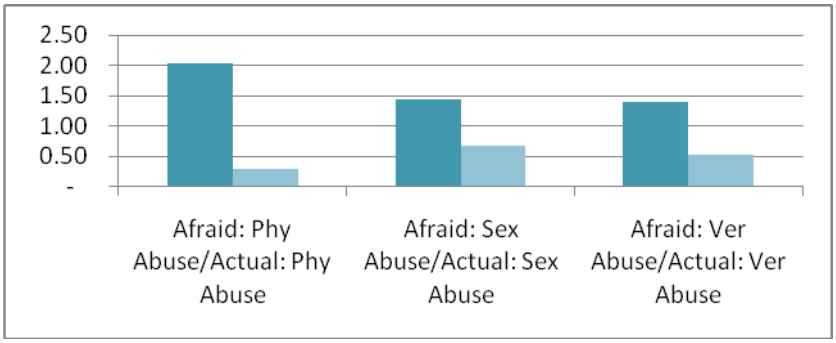

Figure 6 Fear Versus Actual Experience of Physical, Sexual, and Verbal Attacks

DISCUSSION

Majority of the respondents were adult gay homosexuals. Despite Thailand's openness to homosexuality, it was quite a surprise to yield results that depict feelings of isolation among the respondents. Majority of them admitted to feel like they do not belong in their present community that could and may have possibly resulted to them turning on alcohol as a form of coping with their situation. Contrary to the respondents' feeling of isolation, the survey revealed that they are actually not vulnerable to depression. Yes, they may have little interest over activities, but the other components in the somatic symptoms of depression and well-being tables show normalcy. What is pressing though are the results in victimization. They fear to be physically assaulted, though physical assault scored the lowest on actual experience. And the highest abuse they get (sexual) is something that they do not consider as the most fearful of. Ironic or just being natural?

Two researches came up that can relate to one of the results of this study. Herdt and Boxer (as cited in Poon & Ho, 2002) stated before that HIV infection, developmental stage, and homophobia lead to feelings of rejection, loneliness, low self esteem, and depression. Furthermore, Poon and Ho (2002) once concluded that psychological stress leads to social isolation. Although the current study was able to gather more adult respondents as compared to the youth respondents of Poon and Ho, it still yielded results which express that they really do not socially belong, feeling socially isolated and unaccepted by the community. Still on the same premise of Hurdt and Boxer (as cited in Poon & Ho, 2002) regarding the effects of developmental stage to feelings of rejection, loneliness, low self-esteem, and depression, this research can attest some truth to this. The former had LGB youths as respondents while the latter mostly had early adults. On the former's research, there was a high rate of distress while the latter had extremely low rates that may been caused by the present developmental stage of the participants. Three researches concluded that LGB youths have high rates of destructive behaviors and more suicidal attempts that lead to some depressive symptoms (Remafedi, Farrow, and Deisher, 1991; Huxdly & Brandon, 1981; Remafedi, et al., 1991; and Herrell, 1999 as cited in Martel, et al., 2007). Again in relation to that premise on developmental stage, this current research may prove it right, since its adult male homosexuals scored the lowest in suicidal ideation. Should the youth dominated the respondents, together with the environment (Safren & Heimberg, 1998 as cited in Martel, 2007), then the results would have also changed.

Herrel in 1999 (Martel, 2007) concluded in his study that suicidality cannot be explained by drugs and alcohol. The current research can attest to this since it yielded a very low score in ideation versus the high rate of admittance of being alcohol users among its respondents. And this is contradictory to that of Murphy in 2005 where victimization was associated to depression, alcohol use, family and peer suicide, thus resulting to suicide. Among researches with adult gay respondents, almost all four assert that gay and bisexual men are more susceptible to Major Depressive Disorder, Panic Disorder, and other psychological problems than their heterosexual counterparts (Gallego, Gordillo, and Catalan, 2000; Sullivan, 2003; Martel et al., 2007; and Cochran and Mays, 2007). Though each research was strongly supported by the other, this research concludes otherwise although its adult male Thai homosexuals are seen to have tendencies to MDD, but is not strong enough to verify the previous findings. Again, the environment and culture may have been of significance.

The messages of this research are clear: (1) Though there were a lot of researches gathered, the data still do not suffice to back up this current study due to differences in race and nationality (other researches' respondents were mostly American), differences in culture and environment as brought about by race and nationality, and age and developmental stage, although this current paper did not actually aim for adult male homosexuals. As discussed in the earlier part of the investigation, cultural factors may have also hindered the abundance of the availability of the researches in this particular field. To top it all, researches that deal with depression also have proven to be scarce more particularly in Asia; and (2) Independent of the previous data collected on LGBTs, on Gays alone, on MDD and LGBTs, this research is clear that Thai Male Homosexuals have expressed their needs and their fears that need to be addressed. With the survey conducted among the selected population, an assessment of their pressing need to be deviated from the symptoms of MDD, be protected from victimization and need to be educated of healthier coping mechanisms than turning to alcohol has surfaced. Acceptance of this population is indeed important.

CONCLUSION AND RECOMMENDATION

Despite Thailand's culture and acceptance of homosexuality, gays in the country have needs just like any other gays in the United States, New Zealand, Canada, South Africa, etc. Despite their openness to the public, there are still some distresses that make them feel different and alone. Instead of turning to drugs, they resort to drinking alcohol. Results also revealed Thai gays vulnerability to depression.

After needs assessment, programs of cognitive and behavioral by nature, creative therapy, and psycho-education are suggested. Programs should not only empower the gays but also teach them proper ways to cope with desolation. These programs should also include not only those with traditional or conservative therapy, but also counseling, or group activities to ensure their participation. Psycho-education therefore should not force deviancy to be out of the picture but should rather help non-gay individuals (heterosexuals) to deal with the presence of their homosexual counterparts. Networks with the various gay groups in the country should be made in order to solicit support in funding and manpower. These organizations may also be a source of empowerment for all other gay men who still feel isolated.

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