

Experiences of LGBT People with Serious Mental Illnesses: Raising Issues

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This is a summary (Sept. 2000) of a much larger report, which is not yet available. Please feel free to contact me for additional information about the topics covered.

Please do feel free to copy and distribute this summary, as long as this title page and my contact information are included in any copies. Thanks!

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τΔτ Project Overview τΔτ

In 1997 the federal Center for Mental Health Services asked that a monograph be written drawing together existing information on the experiences of lesbians, gay men, bisexual people and transgender people (LGBT) receiving mental health services in the public sector. Usually such “monographs” are academic literature reviews. In this case, however, there is very little literature to review. While there is a growing body of work in counseling & clinical psychology, social work, and psychiatry on psychotherapy with gay and lesbian clients (less re Bi and Trans people), it focuses on coming out issues, general problems in living, and the stresses of living as LGBT in a intolerant society. It does not address serious mental illnesses, services other than therapy (inpatient hospitalization, day or residential programs), or the public mental health system.

Therefore, this project combined the slim relevant professional literature with information from grass roots publications, recordings, and first-person accounts (published and unpublished) through extensive networking and conversations with Key Informants (mental health consumers, providers, advocates and other with particular knowledge in this area).

The resulting report raises issues and questions rather than giving answers. Its purpose is to assist LGBT mental health consumers in having their views and voices heard – by mental health workers, by LGBT communities, by psychiatric consumer/survivor groups, and by mental health systems. With it, I also hope to spark interest and concern so that next steps may be taken and problems addressed. Finally, I also hope this report can put interested people in touch with each other – feel free to share it!

This summary highlights main themes from the monograph with brief topic summaries and first-person quotations. However, it necessarily leaves out many important issues, points, and quotes included in the full monograph. If you want or need further details or the entire (100 pg) report, please get in touch!

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“In the mental health system, we had to be closeted about being a sexual minority. There was no place we could feel at home, not be guarded because of fear of ridicule and rejection, and fully share who we are.” (Holochuck, 1993. p. 17)

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τ **No one is addressing the concerns of LGBT people with serious mental illnesses.**

- Existing LGBT affirmative therapists / centers often cannot address serious mental illnesses.
- Staff at general mental health services often cannot address the needs of people with LGBT identities.
- LGBT communities are often afraid of mental illness and full of stereotypes, just like rest of society.
- Mental Health consumer self-help organizations are often afraid of LGBT issues and full of stereotypes, just like the rest of society.
- There is no research in this area, no health administration policy, and discrimination is legal in most places.

“Any knowledge you could put out through the report would help. There is a woeful lack of knowledge all over. Even places that are relatively gay friendly – even gay clinicians – don’t know much about treating gay patients [with serious mental illnesses]” (staff member)

“For individuals diagnosed with serious mental illness who are LGBT, homophobic attitudes among providers of mental health services, and mental health programs which are heterosexist, create barriers to recovery and detract from the effectiveness of treatment and support services. (Chassman, 1996, p. 1-2)

τ **Often, consumers’ emotional and sexual life in general is not addressed except as a problem.**

- Many day, residential, inpatient, etc programs see any sexuality / relationship as disturbed or disturbing,
- Most make no provisions for learning about or having healthy adult intimate relationships (sexual or not)
- Most seem to want to see consumers are having no sexuality, including heterosexuality, but LGBT identities/behavior are even more stigmatized

“At the state hospital outpatient clinic...the staff tend to deny the sexuality of all patients. There’s this sense of patients as children, who don’t have a sexuality, or that it wouldn’t be good for them to be sexual. Staff don’t seem to want to deal with it. For example, a community residence locally that has a rule that residents cannot have sex in the house, [but] they don’t really provide other guidelines or information, don’t really address sexuality. More it seems they just don’t want to know about it –so, not in the house.” (Consumer)

“When I tried to develop a safe-sex workshop for clients...it took me weeks to get the staff to OK it. They were afraid that it would be too “stimulating” for the clients, would turn into a sex orgy. In reality it is quite different.... Clients are just thankful that someone is addressing sexuality issues in a positive open way – or at all. I’ve noticed the clients often really get organized and ask really good questions.” (Psychiatrist)

τ Staff Homophobia and Ignorance is not addressed

- Consumers experience many mental health workers as fearful: don't understand, don't know about, don't like LGBT identities and so don't treat the people well, and don't want to deal with relevant issues.
- Many staff hold stereotypes that LGBT people are all HIV positive, sexual predators, hate men, are swishy, are butch, are confused, are sick. Subtle to blatant pathologization of LGBT identities is rampant.
- Knowledge of and respect for LGBT consumers is not covered in staff trainings or program policies.

“It took me a long time to build my life back up again after that [a disastrous phone call to family made at the insistence of her social worker]. I believe that the social worker did not really have any idea about the issues of a family totally disowning someone for being gay – how strong homophobia is, and that it is not going to be ‘cured’ by a phone call.” (Consumer)

“Some [staff] see something bad in the gay community and (1) stereotype us by assuming that we're all like that just because we're gay. Then (2) they don't even think about how many really bad problems are going on that impact the gay community and cause the things they're seeing – how homophobia, AIDS, problems with families, isolation, all that, effect people.” (Consumer)

τ Peer Intolerance is also an unaddressed problem

- LGBT consumers report frequent harassment and belittlement from clients attending the same programs.
- Consumer-run self-help groups are often unwelcoming to LGBT consumers
- LGBT communities may be especially reluctant to embrace LGBT consumers given the history of LGBT identities per se being considered mental illness.

“Patients in the system also panic – there is LOTS of homophobia and transphobia, and attacks and harassment. And the staff will usually ignore it, condone it by their inactivity.” (Consumer)

“At the other clinic its OK in group to bring up gay examples (like, “I wish had girlfriend”), but no one joins in the discussion except the therapist. No one else is out, straight members don't join in even though they have exact same issue...When I bring up gay things the conversation stops.”

τ Family Stress around being LGBT, a Consumer, and both, can be considerable

- People with serious mental illnesses often rely on family members – for direct help or in knowing they are there as resource of last resort for housing, money, emotional support. Many LGBT consumers cannot count on this, cannot go home, and so do not have this safety net. Or, they have it, but at a high price of active conflict, stress, and/or being closeted, isolated.

“I, for example, came out to my family 13 years ago and was immediately disowned. Despite efforts to contact them, cards and gifts sent, etc, I have never seen another single member of my family again, even though my sister, nieces and mother live only 35 miles away. I was told that I would be arrested for trespassing if I tried to visit them. Although extreme, this is not entirely atypical of the [LGBT] consumers' experience at the Alliance.” (Consumer, peer advocate)

“I am bisexual and...living with an abusive father (finances keep me at home) I cannot at least for now even hint of such a possibility to my immediate family. There's been enough trouble...I fear they would call me crazy, just for [being bisexual].” (Jim Haller, 1996, p. 1)

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These add up to many LGBT Consumers spending tremendous energy managing identity, self presentation, fear/anxiety, and the negative reactions of the very people from whom one would hope to get support: the MH system, peers, family. In addition to their other life challenges.

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τ **LGBT identities are still pathologized**

- **Some providers still see being LGBT as pathology. Some assume that LGBT orientation is not real -- a delusion, a symptom because the person has been diagnosed with a mental illness.**
- **Unfamiliarity and stereotypes lead some staff to interpret adaptive behavior as pathological. For example, self-protectiveness or anxiety about homophobia interpreted as paranoia.**

“The fundamental issue is still that it is NOT a pathology, and the mental health system still is not as accepting as it ought to be of this.” (Consumer advocate)

“It is especially poignant with older clients who have experienced lots of abuse in the mental health system in decades past. They are very very wary about the Mental Health system -- period, and about being out certainly. Usually they are not out at all on the unit, and are reluctant to talk about it openly. I think this is due to years of misuse at the hands of the mental health system. In our LGBT support group, elderly gay and lesbian clients have talked about receiving ECT and aversion therapy (electric shocks applied to their genitalia when they respond to same sex erotica). Those with chronic mental illnesses like schizophrenia, for example, talk about not being seen as cured or the exacerbation being seen as in remission because the client “still” maintained attractions to members of their own sex.” (Psychiatrist)

τ **Programs/systems have little information or resources about LGBT-affirmative community and MH services:**

- **If I go to the day program can I expect hostility if I’m out or outed?**
- **If I live there will staff or other residents harass me?**
- **Does anyone there know anything about LGBT issues?**
- **Isn’t the LGBT community part of the “community integration” I’m supposed to be striving for?**

“[Once] I and another staff-person did an in-service on GLB issues. People asked very basic questions and did not know of even the most common community resources we listed. (Staff)

“According to Diane Johnson, president of Lambda Human Service Professionals, acknowledging service recipients’ sexual orientation is critical to developing individual service and discharge plans which reflect the recipient’s goals and choice” (OMH News, 1994, in Chassman, 1996, p. 2).

“Here in San Francisco...we’re fortunate to have a pool of sensitive or at least interested practitioners to draw from in discharge planning and community services for people leaving [our unit]. Others might not elsewhere, and that would change things a lot. What services any hospital

or program can provide depend on the available professionals and the politics in the surrounding area. Politics and health care certainly intermix. (Clinician)

τ **Inpatient and Residential/Housing services may be especially high risk for LGBT consumers**

- **LGBT people treated with suspicion, assumed to be sexual predators toward same gender staff, patients (especially roommates), watched, behavior over-interpreted.**
- **High level of harassment, discrimination, even physical assault, and staff disregard or blaming the victim.**

“Within any residential system – psychiatric, shelters, domestic violence shelters -- it is gender binary: women, men. Which dorm? Which wing? Which bathroom? If you don’t fit easily the staff get very upset. Other clients too. And its very very frightening for the client – the level of alienation and hostility, and danger, they can be in.” (Consumer / provider)

One person related a time when he felt attracted to another man who slept nearby on the hospital ward. He asked the nurses if he could sleep in another area, and had to tell them the reason. He was given another place to sleep, but the next day everyone on the floor knew about the request. In fact, the story had grown as it was passed around so that some people thought he had been ‘caught’ in an intimate act with the man or had aggressively pursued him. He recalls that a doctor said to him, “scum like you should be locked up,” and was not interested in hearing his version.

“Just recently in our group a 23 year old Latina woman in chronic treatment, in a residential program, was outed by a person she thought was a friend, and who she had told she was a lesbian in confidence. The friend went to the whole house, and the woman was harassed a lot and was very upset. We spent most of the afternoon meeting of our group helping support her.” (LGBT consumer support group leader)

τ **Providers may exhibit superficial sensitivity, but with little depth**

- **Service providers who know a little about LGBT people may be prone to stereotyping and uncomfortable with their own discomfort.**
- **They may also tend to assume/insist being LGBT is “no big deal,” or may insist on it as a focus even if client says its not the problem.**
- **They may shy away, or pathologize, client needs or conversations that go deeper than their own**

“Mental health workers often put on how advanced, knowledgeable, OK they are with GLBT and HIV topics, but if you scratch the surface at all you find they don’t know much, they really aren’t comfortable with it, and they don’t want to deal with it – with others’ issues or their own. They’re just trying to appear sensitive without really being so.” (Consumer)

“I finally got a counselor, but she was the same way.... kind of pseudo-sensitive. She’d jump to conclusions and wouldn’t listen to my real point about things. For example, one time I brought up that things were so bad at home that I didn’t dare even bring home a [LGBT newspaper] She immediately jumped to “Yeah. I’d be ashamed too to be seen with those disgusting personal ads!” She totally missed my point, and [blamed] the gay community as disgusting. I even agree – I think the personal ads are rather filthy. In fact I usually take out that section ...and just take the paper itself. But my point in that example was that (even without the ads) I could not bring it in the house because of the terrible conflict it would create with my mom.” (Consumer)

τ **Rigid gender roles are common in mental health programs, and LGBT people are often pressured to conform to mental health providers' ideas of "women" or "men"**

“On the behavior mod ward they had this system where they gave us tokens for doing what they wanted, and took them away for being bad. You had to pay tokens for anything you wanted to do, even taking a bath. I remember I had this green plaid skirt and matching sweater I used to get tokens for wearing ‘cause they were trying to change me into their idea of a proper woman.” (Blackbridge & Gilhooly, 1985)

“When I was at [the] Hospital, I got in a lot of trouble and was considered seriously depressed because I refused to put on make-up or act in other ways they considered appropriate for females...I was openly gay at the time.” (Consumer)

“Shelters cannot deal with men who are at all effeminate – they get beaten up.” (Consumer)

τ **Mental health workers, including Gay and Lesbian ones, are often very ignorant and prejudiced about issues important to Bisexual and Transgender people**

“Any degree of fluidity re sexuality, which is certainly part of being transgender, makes therapists anxious, even panic. It brings up their own sexuality issues – am I woman or man enough? This panic is then defended against and projected as attack, even hate, toward the client. Gender identity questions, and transgender lead to this panic because gender is even more central to one’s core identity than sexual orientation.” (Consumer advocate)

“As I was going along, most often my therapists didn’t know anything about being transgender. I had to educate them. It really bothered me, and changed the whole therapy dynamic and takes away from the trust you feel, and the time spent on you, even though that’s why you are there.” (Consumer/provider)

Effects of These Issues

τ **Stress and energy taken from rehabilitation and learning**

τ **Frustration, anger, depression**

τ **Safety concerns**

τ **Absence of / Barriers to useful services**

τ **Fear, isolation when need community integration**

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τΔτ Expressly LGBT-affirmative Services τΔτ

In addition to individual mental health workers who are well informed and experienced in providing care to LGBT people with serious mental illnesses, there are several clinics in the U.S. that bring this competence to a programmatic level. The ones I have been in touch with are profiled in the monograph, as are the few consumer-run self-help and advocacy groups made up of LGBT people with serious mental illnesses.

Although the time and funding to do program evaluation/comparisons has not been available, people from both anecdotally say that receiving services in a well-informed, expressly LGBT-affirmative program does make a difference:

- τ **Clients feel more comfortable and safe, which facilitates trust in therapeutic relationships and openness on the client's part.**
- τ **Knowing one does not have to constantly worry about reactions and intolerance, nor constantly monitor one's self presentation seems to allow LGBT identities to be LESS of an issue, allowing clients to better concentrate on the mental health issues they are trying to address.**
- τ **Services are provided that better address the clients' real-life needs, are more tailored to the client's life, re discharge planning, aftercare, housing, community integration.**

“Usually in other places I’ve found that if a counselor is bad to talk to on one thing, doesn’t want to hear you out...then you don’t want to talk to them on other things. It effects trust, and can make it hard just to get yourself to go. Here people are more comfortable with each other, more knowledgeable about themselves and issues, more aware of social problems, and more involved with each other. They don’t take just a medical view [of] “medicate and go.”...So, I feel I can be more up-front regarding all the complex parts of homosexuality, and of HIV. Communication is more open – so that if there is some tension or problem it can be put on the table; communication is much less defensive. (Consumer)

“Instead of pretending [sexual activity on the unit, despite official prohibitions] doesn’t happen, [our unit] tries to address it openly. We encourage people to think about, talk about, and express sexual feelings in thoughtful, adult ways...To not enter into unhealthy relationships... To talk about sex. To masturbate if they want to.” (Inpatient psychiatrist)

“Posting information, posters, books, brochures on LGBT issues and organizations is part of creating an affirmative environment.”

“...There needs to be a way to make sure we have clinicians who can provide the services that are needed, including gay-affirmative MH services. Its not the sexual orientation of the trainees that matters, but their willingness to learn the information, and their interest in being educated and sensitive in this area.”